STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING _____ B. WING _____	02/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

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F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure survey. This survey was done in conjunction with the investigation of complaint number - IN00085321 Survey dates: February 21 - 25, 2010 Facility number: 000222 Provider number: 155329 Aim number: 100274950 Survey team: Debora Barth, RN, TC Brenda Buroker, RN Donna Downs, RN Lois Corbin, RN Census bed type: SNF: 20 SNF/NF:137 Total: 157 Census payor type: Medicare: 35 Medicaid: 89 Other: 33 Total: 157 Sample: 43 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 3-3-11 Cathy Emswiller RN	F 000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a Post Survey Review on or after March 27th 2011. RECEIVED MAR 18 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director 3/18/11

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F 156	Continued From page 1 The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this	F 156	**F156 Notice of Rights, Rules, Services, and Charges** It is the practice of this provider to ensure that all alleged violations involving the notice to residents of rights, rules, services, and charges are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident #212 was a provided a list of services and items they would and would not be charged for from the facility during their stay. Resident #4 and resident #242 have been discharged from facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice.	3/27/11

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F 156	Continued From page 2 section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 156	The Social Service Director will in-service the Social Service department on the appropriate procedure for notification for residents being discharged from Medicare services. The ED or designee will educate the admissions coordinator on the supplying of residents with the list of services and items that would or would not be covered while residing in the facility. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** An admission, discharge, and transfer CQI will be completed once weekly x4, bi-weekly x2, then quarterly thereafter. A Discharge planning CQI will be completed once weekly x4, bi-weekly x2, and then quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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F 156	Continued From page 3 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to inform 1 of 1 residents in a sample of 3 who met the criteria for Medicaid coverage and non-covered services [Resident #212] and failed to ensure 2 of 3 residents reviewed for discharge from Medicare services received notification two days prior to discharge and the specific reasons for discharge in a sample of 3. [Residents #4 and #242] 1. Interview with the family of Resident #212 on 2/22/11 at 12 noon indicated the facility had not provided a list of services and items they would and would not be charged for during the facility stay. The family indicated the resident received Medicaid services. Interview with Admissions Consultant #1 on 2/23/11 at 1:00 p.m. indicated the facility had a policy regarding goods and services covered and not covered by Medicare and Medicaid and provided the policy. The papers provided for review were to be signed by the resident or	F 156	**recur, i.e. what quality assurance program will be put into place?** The discharge CQI and the admission/discharge/ transfer CQI, will be reviewed by the CQI committee in the monthly QA meeting. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

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F 156	Continued From page 4 responsible party on admission and were specific that the resident had received information regarding items for which they were and were not to be charged. Admissions staff #1 indicated on 2/23/11 that they could not find that paper in the resident's admission paperwork. She indicated they called the resident's daughter on 2/23/11 and she did not have the list either. 2. The administrator was interviewed on 2/23/11 at 1:00 p.m. concerning the Medicare Discharge Notice given to residents. The notice was requested for Residents # 2, 4, and 242. The discharge notice was provided for review for Resident # 2 on 2/24/11 at 8:15 a.m. The administrator was interviewed on 2/24/11 at 3:00 p.m. for any further information concerning Residents # 4 and 242. No other information was provided prior to exit on 2/25/11 at 2:15 p.m. 3.1-4(f)(1)(A) 3.1-4(f)(3)	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an	F 157	**F157 Notify of Changes (Injury/Decline/Room)** It is the practice of this provider to ensure that the Notification of Changes (Injury/Decline/Room) is at all times in accordance with State and Federal law through established procedures. **What corrective action(s) will be taken for those residents found to have been affected by the alleged deficient practice?** MD and Family of resident #279 were notified on 02/06/2011. The resident no longer has a rash present. **How will you identify other residents having the potential to be affected by the same alleged deficient practice, and what corrective action will be taken.** All residents who reside in the facility have the	3/27/11

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F 157	Continued From page 5 existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician was promptly notified of a rash. This affected 1 of 3 residents reviewed for infections/rashes in the sample of 3 who met the criteria for infections/rashes. (Resident #279) Findings include: The clinical record of Resident #279 was reviewed on 2/23/11 at 1:15 p.m. The resident was admitted to the facility on 2/4/11. The Nursing Admission Assessment, dated 2/4/11 at 2:00 p.m. indicated the resident had blisters on her left hip and midback. The admission nursing note, dated 2/4/11 at 2:00	F 157	potential to be affected by this alleged deficient practice. SDC or designee will educate nurses and CNA's on the appropriate reporting and physician/family notification of change in condition including any skin issues. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The DNS or designee will complete a change of condition CQI weekly x 4, bi-weekly x 2, then monthly there after. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality Assurance program will be put into place?** The change of condition CQI's will be reviewed in the monthly QA meeting by the CQI Committee. Deficiency in this practice will result in disciplinary action up to and including	

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F 157	Continued From page 6 p.m., indicated the resident was admitted and had "blisters noted to (L) (left) post (posterior) hip/mid back." Documentation was lacking the physician was notified of the blisters on the resident at the time of admission. Nurses notes, dated 2/6/11 at 9:00 p.m., indicated, "CNA notified this writer of red rash to res (resident) (L) buttock wrapping around coxal (sic) bone to (R) (right) groin. Linear, pus filled colony of blisters noted. C/O (complains of) burning et (and) itching sensation. Supervisor et MD (Medical Doctor) notified. N.O. (new order) Famvir (anti-infective medication used to treat shingles) BID (twice daily) x (for) 7 days. Placed res in contact isolation, moved roommate to different room. Appropriate infx (infection) control measures in place. WCTM (will continue to monitor)." On 2/24/11 at 3:30 p.m., the lack of physician notification of the rash was discussed during interview with the DON (Director of Nurses). No further information was provided for review prior to the exit conference on 2/25/11 at 2:15 p.m..	F 157	termination of the responsible employee.	
F 164 SS=B	3.1-5(a)(3) 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and	F 164	**F164 Personal Privacy/Confidentiality of Records** It is the practice of this provider to ensure that all alleged violations involving personal privacy/confidentiality of records are provided in accordance with State and Federal law through established procedures.	3/27/11

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F 164	Continued From page 7 meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure residents had a private area to meet with visitors. This affected 2 of 3 residents reviewed for privacy in the sample of 6 who met the criteria for privacy. (Resident #114, #6) Findings include: 1. Resident #114 was interviewed on 2/21/11 at 2:37 p.m. The resident indicated he didn't know of any private place he could use to meet with visitors. The resident indicated he generally meets with visitors in his room and his room mate could hear what's being said.	F 164	**What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident #114 and Resident #6 were both educated on location of the area for residents to meet privately with visitors. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective will be taken?** All residents have the potential to be affected by this alleged deficient practice. A sign will be posted on each unit of facility indicating where the private meeting room is located. Information will be added to the admission packet education residents and families on where the location of private meeting area. **What measures will be put into place or what systemic changes will you make to ensure deficient practice does not recur?**	

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F 164	Continued From page 8 2. Resident #6 was interviewed on 2/21/11 at 3:36 p.m. She indicated she was not aware of any private area that she could use to meet with visitors. Resident #6 had a room mate. 3. The Administrator was interviewed on 2/24/11 at 2:51 p.m. He indicated there were areas like the coffee lounge and north conference room that could be utilized for private meeting areas. He indicated he was unaware if residents knew about the areas in which they could meet. 4. The coffee lounge was observed 2/21/11 through 2/24/11 at random times between the hours of 8:00 a.m. and 4:00 p.m. to be open to the main entryway/hallway of the facility. The room contained the coffee machine and a water dispenser, which were observed to be used by staff, visitors, and residents at various times throughout the hours of 8:00 a.m. and 4:00 p.m. on the first four days of the survey.	F 164	Residents rights CQI will be completed weekly x4, bi-weekly x2 then quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The residents right CQI will be reviewed in the monthly CQI meeting. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	
F 225 SS=D	3.1-3(p)(5) 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225	**F225 Investigate/Report Allegations/Individuals.** It is the practice of this provider to ensure that all alleged violations involving Investigating/Reporting Allegations/Individuals found guilty of abuse are in accordance with State and Federal law.	3/27/11

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F 225	Continued From page 9 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure potential negative comments from staff were thoroughly investigated to ensure no residents were being mistreated. This affected 3 of 8 residents who were interviewed by the facility as part of an investigation of an allegation of abuse. (Resident A, B, C) Findings include: The Director of Nurses (DON) provided the following allegation of abuse/mistreatment for review on 2/25/11 at 8:00 a.m.	F 225	**What corrective action(s) will be taken for those residents found to have been affected by the alleged deficient practice?** A list of residents affected by the alleged deficient practice was not provided. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. Staff will be educated regarding abuse and abuse reporting by the SDC or designee. The DO or ED will educate the department head team on the appropriate procedures of abuse investigations, including investigating concerns identified during resident interviews. **What measures will be put into place or what systemic changes you will**	3/27/11

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F 225	Continued From page 10 "Description of the incident: On 2/22/11 Resident #(13) alleged that one to two months ago employee #1 was providing care and became frustrated and tossed his dentures towards the hutch on the left side of his bed. Resident #(13) alleged that this action caused damages to the resident's dentures." "Injury: No injury noted. No negative psychosocial affects noted." "Immediate Action/intervention: * Resident assessed no injury noted. * No negative psychosocial affects noted * Family and MD (Medical Doctor) notified * Employee #1 immediately suspended * Social services evaluated Resident #1 * Investigation begun." The Social Service Designee (SSD) interview of Resident #13 was reviewed and indicated the following: "SSD interviewed (Resident #13) on 2/22/11 at 10:35 a.m. to follow up on concern disclosed to Guest Services Coordinator on this date. SSD asked resident to share concern, and resident stated that his false teeth were 'destroyed' by an aide. Resident reportedly (sic) approximately two months ago an aide was providing him care, standing at the right side of his bed. CNA reportedly became frustrated while working with resident's dentures and threw the dentures towards the hutch on the left side of resident's bed. CNA continued with care and resident inquired about the dentures, at which point CNA borrowed resident's room mate's reacher to retrieve the dentures from behind the hutch. Per	F 225	**make to ensure that the deficient practice does not recur?** Abuse CQI tool will be completed once weekly X4, bi weekly X2, and then quarterly there after. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The abuse CQI will be reviewed in the monthly QA meeting by the CQI committee. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

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F 225	Continued From page 11	F 225		

resident, his room mate was not in the room at the time. The resident states that when the dentures were recovered, there was damage noted but the CNA insisted that the damage was not caused by her. Resident states the CNA stated the dentures were already in their present condition. Resident reports his lower denture is now missing and his current upper denture is free from noticeable damage.

Resident describes the CNA as 'rotund' (race and gender identified) who he believes is name 'something like (name).' Resident states that the CNA 'runs hot and cold,' and could at times be very pleasant and at times very unpleasant. Resident reports he did not disclose the concern until recently because he had feared she may try to retaliate. Resident denies that CNA has ever (sic) specifically threatened him in any way, but his fear of retaliation is based on her varying moods which he views as 'unstable.' Per the resident, the incident in question was the last time he recalls being cared for by the CNA, as she is not regularly assigned to his hall. Resident states he saw the CNA on this date in the dining room and spoke with her in passing. Resident would prefer that the CNA not be assigned to provide him care in the future.

Resident denies any concerns for his safety or the safety of others in the facility and reported he would be comfortable disclosing concerns in the future. SSD assured resident that any concern would be handled discretely and that RVI (Rosewalk Village) does not allow retaliation. SSD further advised that if resident feels 'uncomfortable,' with a staff or caregiver, he may request a change in caregivers, even if the staff member has not specifically done anything

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F 225	Continued From page 12 upsetting to resident. Resident responded well to assurance. Information obtained in interview forwarded to ED (Executive Director) and DNS (Director of Nursing Services) as part of a continuing investigation." Eight resident questionnaires were included as part of the investigation of this allegation of abuse. These questionnaires included the same five questions asked of all residents interviewed, and included the following: 1. Do you feel safe at Rosewalk? 2. Do you feel that staff treats you well? 3. Do you feel staff treats other residents well? 4. If you had a concern or felt unsafe, would you feel comfortable talking about it with someone on staff? 5. Is there anything else you'd like to share with me about your stay here? One of the eight residents interviewed, Resident B, indicated "sometimes" they feel safe at Rosewalk. Two of the residents (Resident A & B) indicated that staff treats them well "sometimes" and another of the residents (Resident C) interviewed indicated, "yes, when they can" when asked if staff treats them well. There was no follow-up or further investigation as to why residents feel safe sometimes or how staff don't treat them well in order to ensure that residents were not being mistreated. The DON was interviewed regarding the investigation on 2/25/11 at 8:30 a.m. When the investigation was reviewed, including the negative responses by interviewed residents, the DON indicated she would check for further	F 225		

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F 225	Continued From page 13 documentation. No additional documentation was provided for review prior to the exit conference on 2/25/11 at 2:15 p.m. 3.1-28(d) 3.1-28(e)	F 225	**F226 Develop/Implement Abuse/Neglect, Etc Policies** It is the practice of this provider to ensure that all alleged violations involving Development/Implementation of Abuse/Neglect, Etc Policies are in accordance with State and Federal law through established procedures. **What corrective action(s) will be taken for those found to have been affected by the alleged deficient practice?** The social service department met with resident #13 and discussed/educated the resident on abuse reporting and confidentially of resident reporting to ensure resident is not fearful to report further allegations A list of additional residents affected by the alleged deficient practice was not provided. **How will you identify other residents having the potential to be affected by the same deficient practice, and what**	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the written policies and procedures that prohibit mistreatment and abuse were implemented following allegations of abuse/mistreatment and failed to ensure residents were not fearful in reporting allegations. The facility also failed to ensure potential negative comments from staff were fully investigated to ensure no residents were being mistreated. This affected 2 of 3 residents who had voiced an allegation of abuse/mistreatment for which facility provided the investigation for review and resulted in a resident being fearful of reporting the allegation for fear of retaliation. This also affected 3 of 8 residents who were interviewed by the facility as part of an investigation of an allegation of abuse. (Resident #13, #148, A, B, C) Findings include: 1. The Director of Nurses (DON) provided the	F 226		3/27/11

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F 226	Continued From page 14 following allegation of abuse/mistreatment for review on 2/25/11 at 8:00 a.m. "Description of the incident: On 2/22/11 Resident # (13) alleged that one to two months ago employee #1 was providing care and became frustrated and tossed his dentures towards the hutch on the left side of his bed. Resident #(13) alleged that this action caused damages to the resident's dentures." "Injury: No injury noted. No negative psychosocial affects noted." "Immediate Action/intervention: * Resident assessed no injury noted. * No negative psychosocial affects noted * Family and MD (Medical Doctor) notified * Employee #1 immediately suspended * Social services evaluated Resident #1 * Investigation begun." "Preventative Measures: * Employee suspended until investigation completed. * Employee and residents were interviewed with no negative findings. * Employee #1 has no prior history of inappropriate treatment to residents. * Employee #1 stated she dropped dentures on accident * Employee #1 given disciplinary action for inappropriate communication. * Employee #1 re educated on appropriate communication and abuse. * Resident #(13) lower denture will be replaced by the facility." The Social Service Designee (SSD) interview of	F 226	**corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. Staff will be educated regarding abuse and abuse reporting by the SDC or designee. The department head team will be educated on the appropriate procedures of abuse investigations, including investigating concerns identified during resident interviews. Educational material will be added to the admission packet for residents and families on the abuse policy/procedures and how to report any concerns of abuse and reporting confidentiality. **What measure will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Abuse CQI tool will be completed once weekly X4, bi weekly X2, and then quarterly there after.	

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F 226	Continued From page 15 Resident #13 was reviewed and indicated the following: "SSD interviewed (Resident #13) on 2/22/11 at 10:35 a.m. to follow up on concern disclosed to Guest Services Coordinator on this date. SSD asked resident to share concern, and resident stated that his false teeth were 'destroyed' by an aide. Resident reportedly (sic) approximately two months ago an aide was providing him care, standing at the right side of his bed. CNA reportedly became frustrated while working with resident's dentures and threw the dentures towards the hutch on the left side of resident's bed. CNA continued with care and resident inquired about the dentures, at which point CNA borrowed resident's room mate's reacher to retrieve the dentures from behind the hutch. Per resident, his room mate was not in the room at the time. The resident states that when the dentures were recovered, there was damage noted but the CNA insisted that the damage was not caused by her. Resident states the CNA stated the dentures were already in their present condition. Resident reports his lower denture is now missing and his current upper denture is free from noticeable damage. Resident describes the CNA as 'rotund' (race and gender identified) who he believes is name 'something like (name).' Resident states that the CNA 'runs hot and cold,' and could at times be very pleasant and at times very unpleasant. Resident reports he did not disclose the concern until recently because he had feared she may try to retaliate. Resident denies that CNA has ever (sic) specifically threatened him in any way, but his fear of retaliation is based on her varying moods which he views as 'unstable.' Per the	F 226	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The abuse CQI's will be reviewed in the monthly QA meeting by the CQI committee. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

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F 226	Continued From page 16 resident, the incident in question was the last time he recalls being cared for by the CNA, as she is not regularly assigned to his hall. Resident states he saw the CNA on this date in the dining room and spoke with her in passing. Resident would prefer that the CNA not be assigned to provide him care in the future. Resident denies any concerns for his safety or the safety of others in the facility and reported he would be comfortable disclosing concerns in the future. SSD assured resident that any concern would be handled discretely and that RVI (Rosewalk Village) does not allow retaliation. SSD further advised that if resident feels 'uncomfortable,' with a staff or caregiver, he may request a change in caregivers, even if the staff member has not specifically done anything upsetting to resident. Resident responded well to assurance. Information obtained in interview forwarded to ED (Executive Director) and DNS (Director of Nursing Services) as part of a continuing investigation." 2. The record of Resident #148 was reviewed on 2/23/11 at 9 A.M., and indicated nurses notes regarding an allegation of rape on 1/19/11 at 3:30 P.M. "While giving resident mentioned her A.M. medication, resident made a statement to me 'A man came into my room last night & raped me & my roommate.'" Interview with the administrator on 2/23/11 at 9:10 A.M., indicated he was aware of the allegation and would provide the facility's investigation. The investigation was provided on 2/23/11 at 10:10 A.M., and included an interview with the resident's roommate, dated 2/23/11. There was	F 226		

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no name in the documentation to indicate who the resident's roommate was at the time. During interview at that time, SS #2 indicated she would add the name and print another copy. SS#2 indicated the roommate had died in the facility.

The investigation included a skin assessment done on 1/19/11. Interview with LPN #14 on 2/23/11 at 10:45 A.M., indicated the resident assessment completed on 1/19/11 was done by her with another nurse following the allegation. Review of the assessment indicated, " L [left] breast bruise above areola." There were no descriptions of the bruise regarding size, shape, or color. LPN #14 described the bruise as purple, above her areola covering the top of her breast and indicated the bruise was the size of a hand. There was no further investigation or assessment of the bruise. LPN #14 indicated she had been the nurse who received the allegation from the resident when she was giving her A.M. medications. She had immediately reported it to her supervisor LPN #15. There was no documentation in the nurses notes or facility investigation from the charge nurse [LPN #15] that LPN #14 stated she immediately reported the allegation to on 1/19/11.

Interview with the ADoN on 2/23/11 at 2:08 P.M., indicated she had been notified of the allegation on 1/19/11 in the late afternoon after the allegation had been made by the resident. It had been close to second shift when she was made aware. ADoN directed two nurses, one from days and one just coming on for 2nd shift to do an assessment. Social Service started investigating with interviewing other residents. The resident had described the incident involving a male. The male nurse who had worked the night before had

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F 226	Continued From page 18 not been taken off schedule because he was on vacation. There was no statement or interview with the male nurse. 3. The facility policy, "Resident Event Investigation" was reviewed on 2/23/11 at 3:00 P.M., and indicated, "The Charge nurse or department head must conduct a preliminary investigation (see attached forms for investigation instructions) and verbally report findings to the Administrator and or his designee to receive instructions on protecting the residents from further danger including suspension of involved employees. The investigation includes the following information which is to be collected upon identification of an alleged abuse/neglect. "...Also interview the roommate of the resident involved in the event as she/he may have seen or heard something that may be pertinent..." On 2/23/11 at 11:00 a.m., the Administrator provided the policy and procedure for "Abuse Prohibition, Reporting, and Investigation," dated February 2010. The policy/procedure included, but was not limited to the following: "Policy/Procedure: . . .4. Residents and their families are educated as to whom and how to report allegations, incidents, and/or complaints without fear of retribution. . . Resident Abuse - Staff member, volunteer, or visitor: . . .9. Residents will be questioned (if alert and competent) about the nature of the incident, and their statement will be put in writing.	F 226		

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F 226	Continued From page 19 10. An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented. 11. The investigation will include: * Facts and observations by involved employees * Facts and observations by witnessing employees * Facts and observations by witnessing non-employees * Facts and observations from others who might have pertinent information * Facts and observations by the supervisor or individual whom the initial report was made 12. Follow up assessment will be completed/documented during every shift until the resident(s) is stable, and the resident safety is maintained. . ." Eight resident questionnaires were included as part of the investigation of this allegation of abuse. These questionnaires included the same five questions asked of all residents interviewed, and included the following: 1. Do you feel safe at Rosewalk? 2. Do you feel that staff treats you well? 3. Do you feel staff treats other residents well? 4. If you had a concern or felt unsafe, would you feel comfortable talking about it with someone on staff? 5. Is there anything else you'd like to share with me about your stay here? One of the eight residents interviewed, Resident B, indicated "sometimes" they feel safe at Rosewalk. Two of the residents (Resident A & B)	F 226		

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F 226	Continued From page 20 indicated that staff treats them well "sometimes" and another of the residents (Resident C) interviewed indicated, "yes, when they can" when asked if staff treats them well. There was no follow-up or further investigation as to why residents feel safe sometimes or how staff don't treat them well in order to ensure that residents were not being mistreated. The DON was interviewed regarding the investigation on 2/25/11 at 8:30 a.m. When the investigation was reviewed, including the negative responses by interviewed residents, the DON indicated she would check for further documentation. No additional documentation was provided for review prior to the exit conference on 2/25/11 at 2:15 p.m. 3.1-28(a) 3.1-28(d)	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assure 1 of 3 residents reviewed for choices, in a sample of 22 residents who met the criteria for choice selection, were given choices	F 242	**F242 Self Determination – Right to Make Choices** It is the practice of this provider to ensure that all alleged violations involving self determination – right to make choices are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident #23 was interviewed by Social Service in regards to his preferred shower days, times, and other ADL choices. Resident #23's care plan was updated indicating his preferences. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	3/27/11

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F 242	Continued From page 21 concerning the activities of daily living. (Resident # 23) Findings include: Resident # 23 was interviewed on 2/22/11 at 10:00 a.m. He indicated he was not given a choice when to get up, for his dressing, or for his bath schedule. He indicated sometimes he didn't want to go to the dining room, but was taken anyway. He stated, "This is no life for anybody" and "I'd rather be my own boss." The clinical record for Resident # 23 was reviewed on 2/23/11 at 8:30 a.m. The admission minimum data set assessment (MDS), dated 2/6/11, indicated the resident was alert and oriented. It also indicated the resident was extensively dependent on one staff person for assistance with care, was non-ambulatory, and could not even feed himself. There were physician orders, dated 2/22/11, for the resident to eat his meals in the rose cafe dining room for socialization. A psychological evaluation, dated 2/16/11, indicated the resident was depressed and started on an antidepressant drug. The social service progress notes, dated 2/11/11, indicated the resident reported feeling down, had difficulty sleeping, was feeling tired and bad about himself everyday since admission. Interview with RN # 10, on 2/24/11 at 10:30 a.m., indicated the bath times were assigned by the bed the resident occupied unless the resident expressed a different time or day. She indicated this was recorded on the CNA assignment sheet. The CNA assignment sheet was reviewed and	F 242	**corrective action will be taken?** All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Social Service Director or designee will educate the SS department on the appropriate procedure for completing Social History and Psychosocial Assessments including resident choices. Social History and Psychosocial Assessments will be completed upon admission, with significant change, and annually. These assessments will be brought to the weekly IDT team meeting, will be reviewed, and the residents care plans will be updated with the resident's specific wants and needs **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** The Social Service Director or designee will complete	

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F 242	Continued From page 22 indicated Resident # 23 was to receive his baths on Tuesdays and Fridays during the day shift. The Social Services Director # 11 (SSD#11) was interviewed on 2/24/11 at 2:00 p.m. He indicated he inquired of residents what they didn't want for preferences. The decisions about their schedules were made from these responses. He did not ask residents if they had a preference for days or evenings or early morning baths or showers. He also did not inquire if residents wanted to do particular activity of daily living tasks at certain times. 3.1-3(u)(1)	F 242	an accommodation of needs CQI once weekly x4, bi-weekly x2, then quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The accommodation of needs CQI's will be reviewed in the monthly QA meeting by the CQI committee. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure Resident Council concerns were addressed and resolved as evidenced by the review of 8 areas of concern continuing through 11 months of reviewed minutes. Findings include: The Resident Council minutes were reviewed on 2/24/11 at 2:50 P.M.	F 244	**F244 Listen/Act on Group Grievance/ Recommendation** It is the practice of this provider to ensure that all alleged violations involving Listen/Act on Group Grievance/ Recommendation in accordance with State and Federal law.	3/27/11

What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?

A list of residents who may have been allegedly affected by this deficiency was not provided.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All residents who reside in the facility have the potential to be affected by this alleged deficient practice.

Activities Director or designee will hold a monthly resident council meeting. Resident council minutes will be reviewed in the monthly QA meeting and action plans will be developed to correct the areas of concern.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

F9 23 1/2

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F 244	Continued From page 23 Residents expressed concerns about ice water not being passed during the meeting on 4/21/10, 5/27/10, 6/17/10. Residents also expressed concerns of running out of food during the meeting on 5/27/10,10/4/10, and 1/13/11. This was also witnessed during the noon meal observation on 2/24/11. Residents also expressed concerns for cold food during the meetings on 5/27/10, 8/26/10, 9/16/10, and 1/13/11. When queried as to how these problems had been addressed, no further information was presented by the Administrator, Director of Nursing, or Dietician through the final exit of the survey on 2/25/11 at 2:15 p.m.	F 244	Grievances CQI's will be completed weekly x 4, bi weekly x 2, quarterly x 2, then every 6 months thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The grievances CQI's will be reviewed in the monthly QA meeting by the CQI committee. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	
F 246 SS=D	3.1-3(l) 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure resident choices were honored for 1 of 3 residents reviewed for choices in the sample of 4 who met	F 246	**F246 Reasonable Accommodation of Needs/Preferences** It is the practice of this provider to ensure that all alleged violations involving reasonable accommodation of needs/preferences are in accordance with State and Federal law.	3/27/11

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F 246	Continued From page 24 the criteria for choices. In addition, the facility failed to accommodate a resident's needs related to positioning for 1 of 22 residents who resided on Memory Care Unit II. (Resident #279, #282) Findings include: 1. Resident #279 was interviewed on 2/22/11 at 9:25 a.m. When questioned about choices, she indicated the facility did not honor her likes/dislikes for food, but just kept serving the things she did not like. She indicated she doesn't ask for alternates, but, "just don't eat it." She indicated she doesn't like eggs and they send them anyway. She said they "don't listen to me, so I just leave them in my plate." The clinical record of Resident #279 was reviewed on 2/23/11 at 1:15 p.m. The resident was admitted to the facility on 2/4/11. On 2/24/11 at 11:05 a.m., Resident #279's dietary card was reviewed for likes/dislikes. This section of the slip was blank. On 2/24/11 at 3:00 p.m., the Registered Dietician was notified of the resident's dislikes being served at meals. At 4:00 p.m., the Dietician indicated she had interviewed the resident and would be putting the information related to likes/dislikes on her dietary tray slip. On 2/25/11 at 8:30 a.m., the Director of Nurses (DON) provided a copy of the resident's dietary slip which indicated the resident dislikes eggs and apple juice. 2. Resident #282 was observed on 2/21/11 at 11:21 a.m. The resident was seated in a	F 246	**What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Dietary met with Resident #279 and discussed his/her likes and dislikes and updated resident's dietary tray slip to show residents #279 likes and dislikes. Therapy evaluated Resident #282 for chair height positioning at dining room table. Chair height was modified and a high/low table was placed in dining room for resident #282 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. Dietary manager or designee will meet with each resident and complete a nutritional risk assessment and identify residents likes and dislikes on admission, significant	

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F 246	Continued From page 25 wheelchair and pushed up to the table for the noon meal on the memory care unit. The resident's chin was at the level of the table, causing her to have to reach up to get her food and drinks. Spaghetti was served for the meal, along with green beans and a breadstick. Resident #282 first ate her breadstick, while holding it in her hands. At 11:28 a.m., after eating the breadstick, she lifted her dessert bowl and brought it to her lap area, holding it while eating the contents. At 11:40 a.m., Resident #282 had consumed cup of supplement and all of her breadstick and dessert. At 11:42 a.m., the resident attempted to eat her spaghetti with her spoon, leaning forward in the wheelchair, with her left arm on the arm rest to hold herself up. The resident attempted to eat her spaghetti with a spoon, while her fork rested on the back of her plate. As the resident would try to eat spaghetti, part of it, along with the meat in the entree, would drop into her lap and she would then pick it up from her lap and eat it with her fingers. During this time, the resident attempted to scoop some of the spaghetti on the spoon with her left hand. At 11:48 a.m. Resident #282 was still attempting to eat spaghetti with her spoon, and using her fingers to attempt to scoop unbroken long pieces of spaghetti onto her spoon. At 11:55 a.m. the resident finished eating and no staff had intervened. She ate approximately 1/3 of the spaghetti and none of green beans. Staff asked her if she was done at 11:57 a.m. and removed her tray from table without offering anything else	F 246	change, and annually. Tray tracker system will be updated with resident likes and dislikes after assessment is completed. Dietary Manager will be educated by the Registered Dietician or designee on the appropriate identification and documentation of resident likes and dislikes. Department heads will participate in a daily dining room rotation Monday thru Friday, excluding holidays. As part of the observation department heads will identify residents with positioning needs and refer to the IDT team. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** The accommodation of needs CQI's will be completed monthly X 2 then quarterly thereafter. The Meal Service CQI's will be reviewed weekly X 4, bi weekly X2, and then quarterly thereafter.	

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F 246	Continued From page 26 The table height remained the same during observations of the noon meal on 2/24/11. On 2/24/11 at 3:15 p.m. the Administrator, DON (Director of Nurses), and ADON (Assistant Director of Nurses) were notified of the table height for resident and the observation of the meal. The Administrator indicated they would be moving some tables from the Rose Cafe and the ADON indicated resident didn't take meals in that dining area. The Administrator then indicated that he had some high-low adjustable tables in the Rose Cafe that might be able to be utilized. On 2/25/11 at 8:30 a.m., the DON provided the following information regarding the table height for Resident #282: * Therapy to screen positioning at meal times today. * High/low table placed in cottage dining room.	F 246	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The accommodation of needs and meal service CQI's will be reviewed in the monthly CQI committee meetings by the CQI team. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	
F 253 SS=E	3.1-3(v)(1) 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure resident rooms and common areas for residents were maintained in a clean and sanitary manner. This affected 80 of 91 resident rooms, 144 of 157 residents residing in the facility, and 8 of 11 common areas in the facility.	F 253	**F253 Housekeeping & Maintenance Services** It is the practice of this provider to ensure that all alleged violations involving Housekeeping & Maintenance Services are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?**	3/29/11

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F 253	Continued From page 27 Findings include: 1. Room 161 was observed on 2/21/11 at 9:40 a.m. The resident was sitting in a chair facing the window. The resident's room, common bathroom shared between this resident room and room 163 had a strong odor of urine. During a record review of the bed inventory, these two rooms contained 1 resident each. 2. On 2/23/11 at 2:15 p.m. the following was observed: The shower room on the "F" hall was soiled with a brown substance in the tile gout outside the shower area 4 feet in length, with a rubber mat covering the length of it. The edging between the floor and the wall was coming loose to the left of the entry door measuring 3 feet long. Inside the closet, there was an opened bottle of shaving cream, lotion, and deodorant lying on the floor. There was a hole in the entry door (interior side of door) about 2.5 feet from the floor extending 18 inches, and another hole exposing the interior door 3 inches x 1 inch in size. 3. On 2/23/11 at 2: 20 p.m. the unit manager RN/unit manager # 1 came to the F hall shower room when the call light was being checked for functioning. During an interview with the RN/unit manager #1, she indicated this was the F hall shower room. She indicated she did not know what the brown substance was in the tile grout around the exterior bottom of shower "possibly dirt don't know." There were several opened items lying on the closet floor. RN/unit manager #1 indicated they were shaving cream, lotion, and deodorant for individual resident use. When interviewed at that time, she indicated the residents usually have their own individual	F 253	The common bathroom between room 161 and room 163 was deep cleaned. The F hall shower room was deep cleaned and the brown substance on the tile grout was eliminated. The edging between the floor and the wall was repaired. All personal items were removed from closet. The holes on the interior side of the entry door were repaired. Shower rooms were stocked with appropriate cleaning solutions. The entry door frames to the resident rooms on F, G, and H hall have been sanded and repainted. The hole in the soiled utility room on H hall was repaired. The dry rot noted on room 151 door frame was repaired. The clean utility room on F hall was cleaned. The entry door frames to resident rooms on D and E hall have been sanded and painted.	

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F 253	Continued From page 28 personal items, but they might use these items if they forgot to bring their own to the shower room. She immediately picked up all 3 items off the floor and discarded them in the trash can. She indicated the facility process for sanitizing shower chairs included spraying them with use a sanitizing solution then wiping them off. She was unable to locate any of this sanitizing cleaning solution, and checked with another nurse at the nurse's station who said it was in the H hall shower room". 4. On 2/23/11 at 2:25 p.m., RN/unit manager #1 went to the hall H shower room with the surveyor to point out the sanitizing solution used to sanitize the shower chairs. There was one empty 34 ounce spray bottle of comet/bleach liquid. 5. On 2/23/11 at 2:40 p.m. the following was observed: The resident rooms on the F, G, and H rehabilitation halls had entry doors/frames marred and scuffed with black marks with paint chipped off. A record review of the completed facility Bed Inventory sheet indicated these halls contained 35 rooms and 54 residents. 6. During an observation on 2/23/11 at 2:43 p.m., the soiled utility room on the H hall was noted to have a hole in the upper left wall about 2 feet from the ceiling the size of (2) 50 cent pieces. 7. During an observation on 2/23/11 at 2:46 p.m. there was dry rot noted on room 151 door frame 6 inches in length. 8. During an observation on 2/23/11 at 2:48 p.m. the clean utility room on the F hall was found with a paper cup with straw in it, paper cup with drink in it, and a bedspread lying on floor. There was a	F 253	Dining room #1: the scrape on the wallpaper exposing dry wall was repaired. The automatic doors in dining room #1 were repaired. Dining room #2: the wallpaper on the north wall was repaired. The doors to the outside of the building were painted. The door frames on the AC hall have been sanded and painted. The door frame on room C126 was repaired. The scuffs and black marks to the C hall common shower room walls were repaired. The shower chair and cushion were cleaned. The ceramic tile in the shower room was deep cleaned. The C hall clean utility room was cleaned and sanitized. The B hall entry and door frames to resident's rooms were sanded and painted. The common area couch and chair were cleaned. The soap dish rack in the H hall shower room was repaired. The shower chair was cleaned. Memory Care 1 unit entry door frames were sanded and painted. Memory Care	

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F 253	Continued From page 29 pair of disposable gloves inside out appearing to have been used lying on floor, a straw on floor, and another cloth linen lying on floor. 9. During an observation on 2/23/11 at 2:55 p.m., all of the resident rooms on the D and E hall were noted to have door frames/doors scuffed. A review of the facility completed Bed Inventory sheet indicated these two halls had 12 rooms with 24 residents. 10. On 2/23/11 at 3:10 p.m.,dining room #1 was observed. There was a scrape on the wallpaper exposing partial drywall 3 feet in length. The automatic doors in this dining room did not function when the automatic door knob was pressed. Both doors opened when pushed and no alarm sounded. The maintenance supervisor was informed and he indicated he was aware of this and the outside courtyard to the doors was secured with a lock on the fence. 11. On 2/23/11 at 3:15 p.m., the dining room #2 was observed. There was wallpaper scraped off in several places on the north wall. The doors to the outside of the building had door frames appearing to be rust. 12. On 2/24/11 at 7 a.m., the AC hall resident rooms were observed to have entry room doors and door frames scuffed with black marks and paint chipping. In room C 126 outside door frame wood frame was loose from the floor up to 12 inches off floor. A review of the Bed Inventory sheet for this hall indicated there were 14 rooms with 28 residents. 13. The C hall common shower room was observed on 2/24/11 at 7:05 a.m., all walls and	F 253	1 activity area wallpaper was repaired. The common activity area was cleaned by housekeeping. The treatment carts on C hall and H hall were cleaned. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents residing in the facility have the potential to be affected by this alleged deficient practice. SDC or designee will educate CNA's on appropriate shower chair cleaning. Housekeeping supervisor or designee will educate facility housekeepers on appropriate cleaning schedules of activity areas, shower rooms, and utility rooms. Facility department heads will complete daily rounds Monday thru Friday,	

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F 253	Continued From page 30 floor panels were scuffed up with black marks. There was a soiled shower chair witting outside of the shower with a brown substance on the shower chair cushion. The ceramic tile inside the shower was brown appearing unclean. The clean utility room on the C hall had a cushion and blanket lying on the floor. 14. During an observation of the B hall on 2/24/11 at 7:10 a.m., the following was noted: all resident entry way doors and frames were scuffed up with black marking on all doors. The common activity room outside C hall one couch, and 2 chairs soiled with dried stains. During a review of the completed facility Bed Inventory sheet, this hall had 8 rooms with 16 residents. 15. On 2/24/11 7:45 a.m. the H hall shower room was observed to have a 4 inch longitudinal chip off the soap dish rack, empty bottle ketaconazole shampoo fell off shower chair. During an interview at that time with CNA #1, she indicated the empty ketaconazole shampoo belonged to one of the resident's on that hall. The shower room on the C hall had a shower chair sitting outside the shower with a dried brown substance on the shower seat. 16. On 2/24/11 at 8 a.m. the following was noted. The common activity room on the Memory Care I unit had wallpaper coming loose in multiple areas and there was a candy wrapper and straw lying on the carpet floor. The Memory Care 1 unit resident rooms were observed to have resident entry doors/frames in disrepair. A review of the completed facility Bed Inventory sheet indicated this unit had 11 rooms with 22 residents. 17. On 2/14/11 at 8:15 a.m., there were 2 of 8	F 253	excluding holidays and report any findings to the afternoon CQI meeting. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Facility department heads will complete daily routine rounds Monday thru Friday and report any findings to the afternoon CQI meeting. Nursing rounds CQI will be completed once weekly x4, bi-weekly x2, and then monthly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Routine rounds CQI will be reviewed in the monthly CQI meeting by the CQI committee. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	

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F 253	Continued From page 31 treatment carts in the facility (one on C hall, the other on the H hall) with soiled dried spills on the top of the carts with a brown colored looked like dried pudding/food. 18. The Maintenance Supervisor was interviewed on 2/25/11 at 9 a.m. to discuss the multiple findings affecting the resident environment. He indicated he and the Administrator were aware of the situation and were working to correct the situation. He indicated he has several painters and other workers currently in the building addressing these multiple environmental findings. 19. The housekeeping supervisor was interviewed on 2/25/11 at 9:30 a.m. to discuss the housekeeping concerns found during this survey. She indicated she was not aware of any shortage of cleaning supplies or any other issues with the sanitary environment. 20. During an interview with Housekeeper #1, on 2/23/11 at 9:50 a.m., the staff member indicated they have problems having cleaning supplies at most times, especially toilet bowl cleaner and glass cleaner. The Housekeeper indicated on the weekends they have trouble having enough plastic trash bags. 21. On 2/24/11 at 7:21 a.m., Housekeeper #2 indicated they do have difficulty having cleaning supplies available at times. They indicated it is worse on the weekend because the supervisor is not here to have the key to get supplies. According to the Staff Member, it was most difficult to have enough of the general solution used for most cleaning (Quat solution). 22. During interview of the Housekeeping Supervisor on 2/25/11 at 7:45 a.m., she stated	F 253		

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F 253	Continued From page 32 supplies are kept in the housekeeping closet and all Housekeepers have a key. The housekeeping closet was observed with the supervisor at this time. There were two 32 ounce bottles of toilet bowl cleaner and a partially used 1 gallon jug of Quat cleaner connected to the dispensing device. When questioned about additional supplies of the Quat cleaner, the Housekeeping Supervisor indicated additional supplies of it were kept in her office. She indicated she "sometimes" works weekends, but also indicated she checks the supply of Quat before she leaves for the weekend to ensure there is enough as a full jug "lasts for 4 days." She indicated staff did not have a key to her office. This Federal Tag relates to Complaint Number IN00085321. 3.1-19(f)	F 253		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272	**F272 Comprehensive Assessments** It is the practice of this provider to ensure that all alleged violations involving Comprehensive Assessments are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident #134 falls were reviewed by IDT team. Care plans were updated with appropriate interventions related to the root cause of the falls. A New assessment was completed on resident #237 indicating resident does have dentures present. Resident #237 has been	3/29/11

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F 272	Continued From page 33 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to conduct comprehensive assessments related to falls, dental needs and splint use for 3 of residents reviewed in a sample of who met the criteria for assessments. [Residents #134, #237, and #88).] The findings include: 1. The clinical record of Resident #134 was reviewed on 2/24/11 at 8:30 A.M., and indicated a Fall risk assessment, dated 12/27/10, was completed as an admission assessment due to a fracture of pelvis and a seizure disorder. The admission Minimum Data Set [MDS], dated 1/6/11 indicated the resident had a history of falls, needed extensive assist of two for bed mobility, transfer and toilet use. A significant change MDS was completed on 1/22/11. The resident had become totally dependent on staff for bed mobility and transfer and required extensive assistance	F 272	evaluated by the dentist in reference to denture pain. Therapy has evaluated Resident #88 and deemed splints inappropriate at this time and will continue with passive range of motion. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents residing in the facility have the potential to be affected by this alleged deficient practice. The SDNS will educate DNS on root cause analysis of falls. The SDC or designee will educate nurses on thorough nursing assessments including dental assessment. MDS coordinator or designee will educate restorative aides on notifying the IDT team of improper fitting splints or non compliance. Therapy will screen all residents who utilize splints on a quarterly basis.	

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ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 34 for toilet use. Nurses notes, dated 1/17/11 at 8:10 P.M., indicated "Noted res. [resident] on fl. [floor] @ [at] R [right] bedside. 0 [no] injury noted. Res. A & O x 1 [awake and alert times one]. Unable to give reason why on the flr. Res. assisted to bed & Vincent. [incontinent] of bowel @ time of fall. Res. assisted to bed & incont. care provided by staff. Safety precautions in place." Nurses notes, dated 2/5/11 at 7:30 P.M., indicated "Notified by aide res. on flr. Noted res. lying on flr in rm @ ft [room at foot] of bed on res. L [left] side. Also noted w/c [wheel chair] behind res c [with] chair alarm sounding. (res put in rm removed from dinner rm. by other staff from different unit.)" There was no comprehensive assessment following the falls to enable the facility to develop a care plan with interventions to meet the resident's individual needs regarding falls. 2. The clinical record of Resident #237 was reviewed on 2/24/11 at 11:30 A.M. and indicated a nursing assessment dated 1/10/11 related to dental status. The assessment indicated the resident had no upper or lower dentures. The admission Minimum Data Set [MDS] dated 1/16/11 indicated, "None of above" regarding broken or loose fitting full or partial dentures. Interview with the resident on 2/22/11 at 9:47 A.M. indicated the lower dentures hurt his mouth and caused his gums to hurt. He ate with them, but removed them due to sore gums.	F 272	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Assessment CQI's will be completed once weekly x 4, bi weekly x 2, and quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The assessment CQI's will be reviewed in the monthly QA meeting by the CQI Committee Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	

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F 272	Continued From page 35 Observation during the interview indicated the resident had a tooth missing in the upper dentures. Interview with the DoN on 2/24/11 at 3 P.M. indicated she was unaware of dental problems with the resident. Interview with DoN on 2/25/11 at 9 A.M. indicated that they had gotten an evaluation planned for his dental status on 2/25/11. 3. During an observation on 2/22/11 at 2:19 p.m. resident #88 was lying in bed on her back with both knees flexed pointing toward the ceiling. The resident was yelling out for the nurse. The resident did not have splints on at the time. The activity director entered the resident's room and attempted to calm the resident by talking to her and holding the resident's hand. The unit manager RN #3 came to the resident's room and began assessing the resident for pain. RN #3 asked the resident where the location of the pain was. When RN #3 tried to straighten the resident's leg's the resident yelled "ouch that hurts". When asked by the nurse about the pain location, the resident indicated in her feet, her back, her stomach. RN #3 removed the resident socks and reapplied them. The charge nurse LPN #3 entered the room, then left to go check when resident could receive next pain medication. LPN #3 returned to the room and gave the resident crushed Tylenol (a medication for pain) in applesauce. RN #3 indicated the resident was to wear splints on her lower extremities at all times. During an interview at that time with LPN#3, she indicated the resident was supposed to wear the splints but due to pain has not been able to wear them so they have not been putting them on her.	F 272		

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F 272	Continued From page 36 Interview with LPN #3 on 2/22/11 at 2:30 p.m., indicated the resident was on hospice care who visit 3 times weekly. She also indicated the resident had internal bleeding and family did not want the resident to have surgery. On 2/24/11 at 2:44 p.m., during an interview with LPN#2, while referring to the resident's clinical record she indicated the physical therapy notes dated 10/9/10 indicated resident received physical therapy from 9/8/10 to 10/4/10 and the goal was to improve knee range of motion (ROM) and bed mobility. The treatment diagnosis was contracture bilateral knees, muscle weakness. She indicated therapy had been working with the bilateral knee contractures since Sept 2010. LPN #2 indicated the resident is currently in the restorative program for ROM/grooming/and bilateral knee splints to be applied Monday through Friday. She also indicated the resident had been refusing the splints when staff tried to apply them due to pain. She indicated the resident receives Tylenol twice daily routine, along with Norco (a pain medication) 1-2 tablets every 8 hours. She indicated the resident was discharged from PT for dynamic splints for the FIT program and did not specify a date. On 2/24/11 at 3:15 p.m., during an interview with the physical therapy manager, he indicated the resident had received physical therapy and was discharged to the restorative program to continue ROM, and splint usage. The PT manager indicated the PT department was not aware of any problems the resident had with wearing the splints. An medical doctor (MD) order rewrite dated	F 272		

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F 272	Continued From page 37 2/1/11 to 2/28/11 indicated obtain bilateral knee orthosis to reduce bilateral knee contractures and pain, items to be worn indefinitely per schedule upon discharge per PT (physical therapy). Dx (diagnosis): arthritis, dementia;/contractures and pain. Additional dx: hx (history) left hip fx (fracture), status post Orif (open reduction internal fixation), and revision left femur. The physician rewrite also indicated patient was on hospice receiving services three times per week. A nursing care plan currently dated 1/17/11 indicated bil knee splints as ordered. A significant change MDS (minimum data set assessment) completed on 11/3/2010 indicated change "extensive assist with toilet use", functional ROM: no impairment for upper extremity and no impairment lower extremity, mobility devices wheelchair. ... Restorative Nursing programs indicate active range of motion 7 days/week. Training and skill practice in dressing and/or grooming 7 days. MDS plans are to remain in facility (i.e. res currently on hospice services). CAA (care area assessment summary): Based on MDS significant change, the resident triggered for urinary incontinence, and activities. ADL (activities of daily living), functional rehabilitation potential "resident continue to require staff assist with ADL's due to weakness, decreased mobility, and dementia. No change in ADL function noted since last assessment, resident significant change due to weight loss. FIT program for AROM (active range of motion) and grooming utilized to maintain function. Resident is hospice patient. Resident requires extensive staff assist with ADL's, see MDS documentation tool.	F 272		

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F 272	Continued From page 38 During observations of the resident on 2/22/11 at 2:19 p.m., 2/23/11 at 10 a.m., and 2/24/11 at 2 p.m. the resident was never seen with splints on. An interview was done on 2/25/11 at 9 a.m. with the restorative aide who cares for the resident. The restorative aide#1, indicated she has been working with the resident for several months. She indicated she does ROM with the resident daily Monday through Friday, but the resident has been refusing the splints for the last month or so, and one of the splints had to be sent back to the manufacturer due to it was broken. When asked if she reported this to anyone, she indicated she had reported it to RN#3. Interview with RN#3 on 2/25/11 at 9:15 a.m., indicated she was aware of the broken splint and resident refusing the splints but this was PT (physical therapy) responsibility. Interview with the PT manager on 2/25/11 at 9:20 a.m., indicated he was not aware of the resident's broken splint or the resident's refusal to wear the splints. The restorative policy and procedure, received from the DNS on 2/25/11 at 9:30 a.m., indicated there was no documentation to outline the process for responsibilities of when to go back to PT for advise. The DNS indicated the normal protocol would be for the nurse aide to report to the supervisor over the restorative program who would involve PT as necessary. She did not know why this did not occur in this instance.	F 272		
F 279 SS=D	3.1-31(a) 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	**F279 Develop Comprehensive Care Plans**	3/27/11

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F 279	Continued From page 39 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a care plan related to dental services, discharge planning and splint use for 3 of 43 in a sample of 43 residents reviewed for care plans. [Residents #237, 5, 88] The findings include: 1. The clinical record of Resident #237 was reviewed on 2/24/11 at 11:30 A.M. and indicated a nursing assessment dated 1/10/11 related to dental status. The assessment indicated the resident had no upper or lower dentures.	F 279	It is the practice of this provider to ensure that all alleged violations involving development of comprehensive care plans are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** New assessment was completed on resident #237 indicating resident does have dentures present. Resident #237 has been evaluated by the dentist in reference to denture pain. Dental care plan has been created for resident #237. Resident #5 no longer resides in the facility. Therapy has evaluated Resident #88 and deemed splints inappropriate at this time and will continue with passive range of motion. Care plan updated with residents current status. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	

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F 279	Continued From page 40 The admission Minimum Data Set [MDS] dated 1/16/11 indicated, "None of above" regarding broken or loose fitting full or partial dentures. Interview with the resident on 2/22/11 at 9:47 A.M. indicated the lower dentures hurt his mouth and caused his gums to hurt. He ate with them, but removed them due to sore gums. Observation during the interview indicated the resident had a tooth missing in the upper dentures. Interview with the DoN on 2/24/11 at 3 P.M. indicated she was unaware of dental problems with the resident. Interview with DoN on 2/25/11 at 9 A.M. indicated that they had gotten an evaluation planned for his dental status on 2/25/11. Review of the care plan, dated 10/2/10, regarding dental care, indicated, "Res [resident] needs assist with daily personal hygiene." Interventions: "set up and store bathing/grooming supplies for resident's convenience. encourage res to do as much for self as possible." There was no care plan to address the resident's dental needs. 2. The clinical record for Resident # 5 was reviewed on 2/23/11 at 1:20 p.m. The resident had diagnoses which included, but were not limited to legally blind, depression, diabetes, toe amputation, hypothyroidism, congestive heart failure, and pacemaker implantation. The interdisciplinary notes, dated 12/16/10,	F 279	**corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. SDC or designee to educate facility nurses and IDT team on comprehensive care plans. IDT team will review and update all resident care plans upon admission, significant change, quarterly, annually and per Medicare MDS schedule. The social service director or designee will educate the SS department on the development of discharge care plans and the discharge care plan process. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Care plan review and Care plan updating CQI's will be completed once weekly x 4, bi weekly x 2, and quarterly thereafter.	

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F 279	Continued From page 41 indicated the resident was living independently with home health support prior to his surgery and he wanted to return to his home after therapy. The occupational therapy notes, dated 12/23/10 through 1/13/11, indicated the resident was making progress toward his short term goals. The resident was discharged from physical therapy on 12/22/10. The nursing notes, dated 2/22/11, indicated the resident was tolerating therapy with no complaints. The care plan, dated 2/16/11, included the following areas for care and assistance: nutrition, communication, impaired vision, adl (activities of daily living) deficit, diabetes, Aspirin medication use, pacemaker implant, anemia, diuretic use, lung disease, pain, fall risk, choking risk, skin risk, depression, high blood pressure, and dehisced (split open) incision. There was no plan for the resident's discharge in the care plan. There was no mention of the discharge in the social service notes. SSD # 11 (Social Services Director for the rehabilitation unit) was interviewed on 2/24/11 at 8:45 a.m. He indicated he had regular contact with the resident's Power of Attorney who was concerned for the resident's safety living alone. He also indicated it had been discussed to have the resident's home and ability to care for himself in that setting evaluated by the Physical Therapist when the resident was ready to return to home. SSD # 11 indicated none of these things had been recorded in his notes or put into a plan for the resident.	F 279	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The care plan review and care plan updating CQI's will be reviewed in the monthly CQI meeting by the CQI Committee Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	

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F 279	Continued From page 42 3. During an observation on 2/22/11 at 2:19 p.m. Resident #88 was lying in bed on her back with both knees flexed pointing toward the ceiling. The resident was yelling out for the nurse. The resident did not have splints on at the time. During an interview with unit manager/RN #3 at that time, she indicated the resident was supposed to wear splints on her lower extremities at all times. During an interview on 2/22/11 with LPN#3, she indicated the resident was supposed to wear the splints, but due to pain had not been able to wear them so they had not been putting them on her. On 2/24/11 at 2:44 p.m., during an interview with LPN#2 on 2/24/11 while referring to the resident's clinical record, she indicated the resident was currently in the restorative program for ROM (range of motion)/grooming/and bilateral knee splints Monday through Friday. She also indicated due to pain the resident had been refusing the splints when staff tried to apply them. She indicated the resident was discharged from PT (physical therapy) for dynamic splints for FIT program and did not specify a date. On 2/24/11 at 3:15 p.m., during an interview with the Physical Therapy Manager, he indicated the resident had received physical therapy and was discharged to the restorative program to continue ROM (range of motion) therapy and splint usage. The PT manager indicated the PT department was not aware of any problems the resident was having with wearing the splints. An medical doctor (MD) order rewrite dated 2/1/11 to 2/28/11 indicated "obtain bilateral knee orthosis to reduce bilateral knee contractures and	F 279		

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F 279	Continued From page 43 pain, items to be worn indefinitely per schedule upon discharge per PT (physical therapy)"... A nursing care plan dated 1/17/11 deemed current indicated bil (bilateral) knee splints as ordered. During observations of the resident on 2/22/11 at 2:19 p.m., 2/23/11 at 10 a.m., and 2/24/11 at 2 p.m. the resident was never seen with splints on. During an interview on 2/25/11 at 9 a.m. restorative aide#1 indicated she had been working with the resident for several months. She indicated she does ROM with the resident daily Monday through Friday, but the resident had been refusing the splints for the last month or so, and one of the splints had to be sent back to the manufacturer because it was broken. She indicated she had reported this to unit manager/RN#3. During an interview with unit manager/RN#3 on 2/25/11 at 9:15 a.m.,she indicated she was aware of the broken splint and the resident refusing the splints but this was PT (physical therapy) responsibility. During an interview with the PT manager on 2/25/11 at 9:20 a.m., he indicated he was not aware of the resident's broken splint or the resident's refusal to wear the splints. A facility restorative policy and procedure was received from the DNS on 2/25/11 at 9:30 a.m. There was no documentation to outline the process for responsibilities for when the restorative program staff should consult with PT. The DNS indicated the normal protocol would be	F 279		

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F 279	Continued From page 44 for the restorative nurse aide to report to the restorative supervisor who would involve PT as necessary. She did not know why this did not occur in this instance. 3.1-35(a)	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents with rashes received prompt treatment, thorough assessment, and interventions as needed to promote the healing of the rashes. This affected 3 of 4 residents reviewed with rashes in the sample of 6 who met the criteria for rashes/skin conditions. (Resident #6, #56, #279) Findings include: 1. The clinical record of Resident #279 was reviewed on 2/23/11 at 1:15 p.m. The resident was admitted to the facility on 2/4/11. The Nursing Admission Assessment, dated 2/4/11 at 2:00 p.m. indicated the resident had blisters on her left hip and midback. The admission nursing note, dated 2/4/11 at 2:00	F 309	**F309 Provide Care/Services for Highest Well Being** It is the practice of this provider to ensure that all alleged violations involving providing care services for highest well being are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** The rash to Resident #279 is now healed no further treatment needed. Rash is currently healed for Resident #56. Resident #56 still has cellulitis to lower extremity. Resident is currently receiving antibiotic therapy and treatment to cellulitis. Resident has appointment scheduled on March 31, 2011 to be evaluated by a dermatologist. Resident #6 had appointment on 03/15/2011 with dermatology. Resident #6 is currently	3/27/11

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F 309	Continued From page 45 p.m., indicated the resident was admitted and had "blisters noted to (L) (left) post (posterior) hip/mid back." Documentation was lacking the physician was notified of the blisters on the resident at the time of admission. Nurses notes, dated 2/6/11 at 9:00 p.m., indicated, "CNA notified this writer of red rash to res (resident) (L) buttock wrapping around coxal (sic) bone to (R) (right) groin. Linear, pus filled colony of blisters noted. C/O (complains of) burning et (and) itching sensation. Supervisor et MD (Medical Doctor) notified. N.O. (new order) Famvir (anti-infective medication used to treat shingles) 500 mg (milligrams) BID (twice daily) x (for) 7 days. Placed res in contact isolation, moved roommate to different room. Appropriate infx (infection) control measures in place. WCTM (will continue to monitor)." The next nurses note to address the rash was on 2/9/11 at 5:00 a.m. and indicated, ". . .Rash persists, on Famvir 500 mg as ordered. Call light is within reach in room." There was no description of the rash or of the resident's response to treatment. On 2/9/11 at 2:45 p.m., nurses notes indicated Resident #279 was transferred to Memory Care Unit I and was "on contact isolation." The note indicated the resident was oriented to the unit, her room, and her roommate. The next nurses note entry related to the rash occurred on 2/13/11 at 1:00 p.m. The note indicated, ". . .Skin w/d (warm and dry) to touch (with) res (resident) cont (continue) to scapped	F 309	receiving continued treatment for her rash. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who reside in the facility have the potential to be affected by this alleged deficient practice. SDC or designee will educate nurses and CNA's on the appropriate reporting and physician/family notification of change in condition including any skin issues. SDC or designee will educate facility nurses on accurate weekly skin assessments and documentation. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** The assessment CQI will be completed monthly X 2	

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	155329	A. BUILDING _____ B. WING _____	02/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 46 (sic) over area on hip et (and) back et no active drainage noted et ATB (antibiotic) finish this shift (with) no adverse effect noted. . ." Nurses notes on 2/10/11 at 10:30 p.m. indicated, ". . .Area to back & hip (no) weeping starting to scab over, denies pain or itch. res cont (continues) on contact isolation. . ." Further nurses notes indicated the following: 2/17/11 7:00 p.m. "area to back scabbed over. . ." 2/21/11 12:45 (no a.m. or p.m. indicated) ". . .Shingles back & hip scabbed over. . ." 2/21/11 3:40 a.m. ". . .Shingles drying." 2/21/11 12 noon ". . .no skin break noted do have scab areas on back et buttock (sic). . ." Resident #279 was interviewed on 2/22/11 at 9:25 a.m. During the interview, an isolation cart was observed in the resident's room and a sign on the door indicated visitors were to report to the nurse prior to entering the room. The DON (Director of Nurses) was interviewed on 2/23/11 at 3:30 p.m. regarding the placement of isolation (contact precautions) on 2/6/11 and the moving of the resident's roommate from the room and later moving the resident to another unit with a roommate. The DON indicated she would research the matter. On 2/25/11 at 8:30 a.m., the DON provided information which indicated the resident was placed on contact precautions related to the diagnosis of shingles. She indicated the facility	F 309	then quarterly thereafter by the CQI Committee The ADNS or designee will complete a change of condition CQI weekly x 4, bi-weekly x 2, and then monthly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The assessments CQI's and change of condition CQI's will be reviewed in the monthly CQI meeting by the CQI Committee. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	

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F 309	Continued From page 47 had no policy for isolation for shingles but the facility only requires standard precautions for shingles since shingles is only contagious to those who have not had chicken pox. The policy for "Implementing Standard Precautions," dated July 08, was provided for review by the DON on 2/25/11 at 9:15 a.m. The policy indicated: ". . .3. When a resident has a rash or skin lesion. a. A rash or skin lesion on a resident's body can be due to any number of causes. b. A critical index of suspicion is essential to determine if the rash is due to: Varicella (chicken pox or shingles) Scabies Impetigo Herpes Simplex Syphilis A drug reaction Other causes c. The most important intervention for rashes or skin lesions is to inform the physician and determine its cause promptly. d. Many times prompt recognition of the rash, identification of the cause, and prompt appropriate intervention can prevent transmission to the HCW (health care worker) and other residents. e. Wear gloves when care involves contact with the rash. A gown may be necessary. . ." On 2/23/11, a physician's telephone order indicated the resident was removed from isolation precautions secondary to the areas being healed. 2. Resident #56 was interviewed on 2/22/11 at 12:00 noon. The resident complained of itching all over her body, especially her arms. She	F 309		

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F 309	Continued From page 48 indicated staff told her they wondered if it was related to the laundry detergent because when she goes to bed and covers up, the itching begins. The skin on the resident's arms was red and appeared very dry. There were no open areas noted, but the resident was observed to scratch both arms during the interviewed. The clinical record of Resident #56 was reviewed on 2/23/11 at 1:55 p.m. Nurses notes on 12/9/10 at 3:30 p.m. indicated, "linear rash on chest and abdomen." A physician's order was obtained on 12/8/10 for Ivermectin (anti-parasite medication) 3 mg (milligrams) secondary to a linear rash. Five tablets were to be given on 12/8/10 and repeated in 14 days (12/22/10). Nurses notes indicated the following: 12/11/10 3:00 a.m. ". . .Rash on chest, abd (abdomen), back, legs. sch (scheduled) meds (medications) given. some relief given to res (resident)." 12/13/10 3:00 p.m. ". . .Res continues to have linear rash on chest and abdomen. (no) c/o (complaints of) pain or discomfort." 12/14/10 4:55 p.m. ". . .Res continues to have linear rash on chest and abdomen. (no) s/s (signs/symptoms) of infection noted." 12/15/10 4:55 p.m. ". . .Linear rash on chest and abdomen remains." 12/16/10 4:15 a.m. ". . .Continues (with) rash to chest & abdomen."	F 309		

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F 309	Continued From page 49 Nurses notes continued to indicate the resident had the rash to the chest and abdomen without description/assessment of the rash and the response to treatment. IDT (Interdisciplinary Team Progress Notes) dated 12/9/10 indicated, ". . .appears as reddened & excoriated/puritis sx (symptoms)/linear rash. (no) measurable - just presents as rash. (no) c/o pain to site. NP (Nurse Practitioner) order Ivermectin x (times) 1 & repeat in 14 days. . ." The next IDT note was dated 12/15/10 and indicated, ". . .linear rash remains, appears 100% pink. . .will f/u (follow up) (with) rash if needed if area worsens. . ." Nurses notes indicated the following: 12/16/10 4:15 a.m. ". . .Continues (with) rash to chest & abdomen." Documentation of the resident's skin condition was lacking at the time of record review and there was no documentation of the possibility of the reaction to the laundry detergent as the resident indicated. An IDT note, dated 1/20/11 indicated, "IDT Skin assessment. Res LLE (left lower extremity) appears weeping (with) edema & reddened from rash. Some patches of dry flaky skin. Res has dx (diagnosis) cellulitis. ATB (antibiotic) finished. . ." The next IDT note was dated 2/4/11 and did not address the resident's skin condition. The skin condition of Resident #56 was	F 309		

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F 309	Continued From page 50 discussed with the DON on 2/24/11 at 3:30 p.m. On 2/25/11 at 8:30 a.m., the DON provided documentation regarding the resident's rash and treatment from December 2010. 3. During interview of Resident #6 on 2/21/11 at 3:47 p.m., several scratched areas were observed on her left lower leg. The resident indicated she was unsure what caused the areas. The resident was observed on 2/22/11 at 9:45 a.m., and the areas remained on the left lower leg. A physician's order, dated 2/15/11, indicated, Dermatology consult related to a linear rash with a care plan update of, Problem: Linear Rash and Goal, "Res to be eval (evaluated) & tx (treated)" with Intervention - Order as above. Resident #6's skin condition was discussed with the DON on 2/24/11 at 3:30 p.m. On 2/25/11 at 8:30 a.m., the DON provided information that the dermatology consultation was scheduled for 3/15/11. The DON also provided the weekly shower and skin assessments for Resident #6. Shower sheets, dated 2/16/11 and 2/23/11, indicated no skin condition areas. The "Weekly Skin Assessment," dated 2/16/11, indicated there were no discoloration/rashes and the notes indicated there were "old marks 8 bruises noted to body. . ." The "Weekly Skin Assessment," dated 2/23/11, indicated no discoloration/rashes and indicated there was , "Slight redness under breast. . .light green bruising to abd (abdomen) d/t (due to) insulin injections daily."	F 309		
F 323	3.1-37(a) 483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=D	Continued From page 51 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on record review, interview and observation, the facility failed to ensure falls were thoroughly investigated to determine the root cause for 2 of 3 residents reviewed in a sample of 6 who met the criteria for accidents. [Resident 134 & 100] B. Based on observation and interview the facility failed to ensure the resident environment was free of accident hazards regarding side rails for one resident in a sample of four who had rented beds. [Resident #148] The findings include: A.1. The clinical record of Resident #134 was reviewed on 2/24/11 at 8:30 A.M., and indicated a Fall risk assessment, dated 12/27/10, was completed as an admission assessment due to fracture of the pelvis and a seizure disorder. The admission Minimum Data Set [MDS], dated 1/6/11 indicated the resident had a history of falls, needed extensive assist of two for bed mobility, transfer and toilet use. A significant change MDS was completed on 1/22/11. The resident had become totally dependent on staff for bed mobility	F 323	**F323 Free of Accident Hazards/Supervision/ Devices** It is the practice of this provider to ensure that all alleged violations involving free of accident hazards/supervisions/ devices are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident #134 falls were reviewed by IDT team. Care plans were updated with appropriate interventions related to the root cause of the falls. Resident #100 evaluated by physical therapy for use of walker. Physical therapy has discontinued the resident's walker due to it being no longer appropriate for the resident. Resident #148 side rails to his/her bed were removed. A new bed was ordered from supplier with correct side rail measurements.	3/27/11

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F 323	Continued From page 52 and transfer and required extensive assistance for toilet use. Nurses notes, dated 1/17/11 at 8:10 P.M., indicated "Noted res. [resident] on flr. [floor] @ [at] R [right] bedside. 0 [no] injury noted. Res. A & O x 1 [awake and alert times one]. Unable to give reason why on the flr. Res. assisted to bed & incont. [incontinent] of bowel @ time of fall. Res. assisted to bed & incont care provided by staff. Safety precautions in place." Nurses notes, dated 2/5/11 at 7:30 P.M., indicated "Notified by aide res. on flr. Noted res. lying on flr in rm @ ft [room at foot] of bed on res. L [left] side. Also noted w/c [wheel chair] behind res c [with] chair alarm sounding. (res put in rm removed from dinner rm. by other staff from different unit.)" Investigation for the fall on 1/17/11 at 8 P.M. indicated the fall was unwitnessed and the resident had been in bed sleeping, was in gown and socks, and was incontinent of bowel. "What intervention (s) was put in to place to prevent another fall?" "Res. [resident] skid-strips, bed alarm & chair alarms Non-skid ft [foot] wear." There was nothing recorded in the fall investigation regarding toileting or supervision. Interview with the DoN on 2/25/11 at 9 A.M. indicated she had reviewed what she had written for the interventions and could see where she needed to do a root cause analysis and there should have been toileting intervention. Fall Circumstance for 2/5/11 fall at 7:30 P.M.	F 323	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who reside in the facility have the potential to be affected by this alleged deficient practice. The SDNS will educate DNS on root cause analysis of falls. SDC or designee will educate facility staff on use of assistive devices, following CNA assignment sheets, and care plans. Full house audit was completed on all facility side rails. All side rails measured appropriately. The rental bed company was notified of non compliant side rails on rental their beds. The rental company has discontinued the use of these side rails in this facility. All side rails of any future bed that is rented will be measured by maintenance director or designee to	

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F 323	Continued From page 53 indicated the fall was unwitnessed and the resident had clothes, shoes and socks on; and the resident had last been seen in the dining room. The intervention put into place to prevent another fall was "dycem cushion." Interview with DoN on 2/25/11 at 9 a.m., indicated she was in agreement that root cause analysis had not been completed for these falls. A. 2. The clinical record of Resident #100 was reviewed on 2/23/11 at 8:25 a.m.. The resident had a Fall Risk Assessment, dated 1/7/11, which indicated the resident was at risk for falls related to diagnoses of Osteoporosis, incontinence of urine and/or bowel, demonstration of impaired gait/balance, use of an assistive device, history of non-compliance, and confusion/disorientation. A care plan, dated 7/15/10, and updated through 4/4/11, indicated the resident had a problem of, "Risk for falls, res (resident) assisted with transfers per staff. Amb (ambulates) I (independent) on unit with slow gait." The goal was for the resident to have no falls with injury through the next review. Interventions included the following: Encourage resident to seek staff assist with transfers. Encourage independence with assistance as needed. Assist to transfer as needed. Call light available and answered promptly. Keep walkway uncluttered and well lit FIT (exercise) program Non skid footwear was a handwritten entry on the typed care plan, without the date the intervention was added. Another care plan, dated 7/14/10, and updated	F 323	make sure side rails meet state regulations. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Assessment CQI's will be completed once weekly x 4, bi weekly x 2, and quarterly thereafter. Fall CQI will be completed once weekly x 4, bi weekly x 2, and monthly thereafter. Side rail CQI's will be completed once weekly x 4, bi weekly x 2, and quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Assessment CQI, Fall CQI, and Side rail CQI will be reviewed in the monthly QA meeting by the CQI committee. Deficiency in this practice will result in disciplinary action up to and including	

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F 323	Continued From page 54 through 4/4/11, indicated the resident resided on a special care unit due to her increasing confusion secondary to Dementia. Another care plan, dated 7/15/10, and updated through 4/4/11, indicated a problem of needs assist with daily bathing, dressing, toileting, and grooming due to dementia. The quarterly Minimum Data Set assessment, dated 12/28/10, indicated the resident required the limited assistance of 1 person physical assistance with ambulation. Nurses notes indicated the following: 1/27/11 6:00 a.m. "Patient found sitting on floor in her room on her bottom with her legs straight out. Pt's (patient's) walker was near her but behind her. Vitals (vital signs) taken. . ." The "Fall Circumstance Report," dated 1/27/11 at 6:00 a.m. indicated the resident had been walking around in her room at the time of the fall. The report indicated the resident's clothing was on, but did not indicate if the resident's shoes were on at the time of the incident. The 1/28/11 (no time indicated) IDT (interdisciplinary team) progress note indicated the resident was found sitting on the floor. The note also indicated, "Resident is (I) (independent) (with) ambulation (with) use of walker. . .IDT recommends placing non-skid footwear on @ (at) all times. IDT will continue to follow POC (plan of care)."	F 323	termination of the responsible employee	
	On 2/23/11, upon entering the unit at 8:00 a.m., Resident #100 was up in the dining room area for			

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F 323	Continued From page 55 breakfast. At 9:07 a.m., the resident was observed sitting in a chair in the hallway, just outside dining room. During a discussion with the resident, she put her hand on her left knee and complained of pain in the area. There was no walker in the vicinity of resident and no staff were within close proximity of resident. At 9:22 a.m., the resident was assisted by a CNA to re-enter the dining room for an exercise activity. No walker was used and when the resident stood, she used the chair arms to help herself up. The CNA held lightly to resident's right elbow to ambulate while resident reached down to steady herself with the chair back and edge of entryway into room. The resident walked stooped over at this time, while holding on to the chair back and entryway. The resident's walker was observed in her room after the transfer of the resident. On 2/23/11 at 1:11 p.m., the resident was observed sitting on the sofa in the dining/activity area. A housekeeper was in the room, cleaning tables. The resident's walker was not in the area. On 2/23/11 at 2:20 p.m., the resident was sitting in a chair at a table in the dining/activity room. Her walker to the left of the resident. The clinical record indicated the resident received PT (physical therapy) 5 times per week for 4 weeks to treat her for pain and improve strength in knee. PT was initiated on 1/18/11 and discontinued on 2/7/11. Physical Therapy notes indicated on 1/31/11, the resident ambulated 300 feet twice, using a rolling walker and SBA (stand by assist), with manual and verbal cues for posture and walker placement. The notes indicated on 2/7/11, prior	F 323		

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F 323	Continued From page 56 to discharge on 2/7/11, the resident ambulated 300 feet twice, using a rolling walker and SBA/I assist with verbal cues for posture. B. During observation of treatment to Resident #148 on 2/23/11 at 3:45 P.M., the bilateral side rails on the resident's bed were noted to have large gaps between the metal rails. Measurement at the time indicated the gaps were 5 1/4 inches in width. This was reported to the administrator at 4 P.M. He notified the Maintenance Supervisor. Interview with the Maintenance Supervisor at 4:45 P.M. indicated the resident's bed had been rented and the company had been notified of the need to change the rails. He reported there were four other rented beds and none had side rails with gaps that exceeded 4 3/4 inches, like this resident's. He indicated the rails were to be changed that evening. The Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment-Guidance for Industry and FDA Staff issued March 10, 2006 indicates the FDA (Food and Drug Administration) recommends openings within the rail, between rail supports, under the rail or next to a single rail support and between the rail and mattress should be small enough to prevent the head from entering or being entrapped. The " Hospital Bed Safety WorkGroup (HBSW) " and the " International Electrotechnical Commission (IEC) " along with the FDA recommend the space be less than 4 ¾ inches. Observation of the resident's bed on 2/25/11 at 10:48 A.M. indicated the bed rails had been	F 323		

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ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

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F 323	Continued From page 57 changed to ensure the gaps were less that 4 3/4 inches. 3.1-45(a)(1) 3.1-45(a)(2)	F 323	**F329 Drug Regimen is Free From Unnecessary Drugs**	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident's received medications only with adequate monitoring and/or failed to	F 329	It is the practice of this provider to ensure that all alleged violations involving drug regimen is free from unnecessary drugs are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** IDT team has reviewed #114 physician and psychology progress notes and followed up with the appropriate prescribers for clarification of their observations. Pharmacy recommendations for Resident #146 were reviewed with physicians and necessary orders were obtained. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	3/27/11

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F 329	Continued From page 58 ensure behaviors were monitored and subsequent medication changes related to the behaviors residents were exhibiting. This affected 2 of 10 residents sampled for unnecessary medication review. (Resident #114, #146) Findings include: 1. The clinical record of Resident #114 was reviewed on 2/24/11 at 7:15 a.m. The record contained a pharmacy recommendable, dated 1/1/11-1/8/11, which indicated the resident had been taking Zoloft (anti-depressant medication) 100 mg (milligrams) since 1/09. The recommendation indicated, "Please consider a gradual dose reduction at this time while monitoring for re-emergency and/or withdrawal of symptoms. If therapy is to continue at the current dose, please provide a statement of rationale or indicate one of the following reasons. . ." Documentation was lacking in the record to indicate if the physician had addressed the pharmacy recommendation. On 2/15/11, a physician's order was obtained to increase the Zoloft to 125 mg daily. A care plan update, on the same form as the physician's order, indicated the increase was due to an "increase in depression." Nurses notes on 2/8/11 at 4:00 p.m. did not indicate any problem with increased depression/behaviors. The next nurses note entry was on 2/23/11 (no time indicated) and indicated, "(no) c/o (complaints of) pain. (no) behaviors noted (secondary to) GDR (gradual dose reduction). to monitor."	F 329	**corrective action will be taken?** All residents who reside in the facility have the potential to be affected by this alleged deficient practice. IDT will review psychology and physician's progress notes for all residents who receive a new order for a change in psychoactive medication treatment. Social Services Director or designee will educate facility staff on appropriate documentation of behavior and mood. DNS receives pharmacy consultant recommendations once monthly. These recommendations will be reviewed in IDT meeting. MD/NP will be notified of recommendations. Facility will continue to review recommendations in afternoon CQI meeting, Monday thru Friday until all recommendations have been addressed. **What measures will be put into place or what**	

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F 329	Continued From page 59 Social Service notes on 2/15/11 (no time indicated) indicated, "Note new order written today to (increase) Zoloft 125 mg po (by mouth) dly (daily). Staff reports some tearfulness and sexually inappropriate comments to staff. SS (Social Service) observed res (resident) propelling (sic) self throughout the facility today (as usual)." Documentation was lacking in the nurses notes to indicate the resident was experiencing signs/symptoms of increased depression. The "Behavior Symptom Monthly Summary Form," dated January 2011, indicated the resident received Zoloft for depression and Depakote for aggression. The summary indicated there were no behaviors reported for the month of January and no medication changes. On 2/22/11, a physician's order was written to decrease the Zoloft to 100 mg po daily due to agitation with a care plan update on the same sheet indicating, increased agitation with goal of no agitation. The Social Service Designee (SSD) indicated on 2/24/11 at 8:45 a.m., that there were no behavior sheets for Resident #106 for February 2011. The SSD indicated when a behavior occurs, nursing staff complete a sheet showing what the behavior was and the interventions attempted as well as the resident's response to the intervention. On 2/25/11 at 8:30 a.m., the DON (Director of Nurses) provided the following information: "Nurse practitioner (NP) interviewed resident on 2-15-11 and noted ss (signs/symptoms) of	F 329	**systemic changes will you make to ensure that the deficient practice does not recur?** Unnecessary medication CQI's will be completed once weekly x 4, bi weekly x 2, and quarterly thereafter. The pharmacy services CQI will be completed biweekly x 2, monthly x 2, the quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** IDT team will review Pharmacy recommendations for psychoactive medications monthly. The CQI committee will review unnecessary medication CQI's and the pharmacy services CQIs in the monthly CQI meeting. Deficiency in this practice will result in disciplinary action up to and including	

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F 329	Continued From page 60 depression and he talked a lot about dying and increased Zoloft. 2/22/11 Psych (psychiatric) services noted evaluated resident and noted increased agitation and recommended to decrease the medication. NP verified increased agitation and agreed with Psych and changed the dose." The Psychiatric Note, dated 2/22/11, indicated the following: "Review of increased agitation and the potential of SSRI's (Selective Serotonin Reuptake Inhibitors- type of anti-depressant medications) to exacerbate agitation in patients with dementia, you may wish to consider the medical appropriateness of decreasing Zoloft to 100 mg for control of agitation." Social Service notes, dated 2/23/11 (no time indicated), indicated "Please refer to psych progress note for details as res. (resident) received psych services yesterday with new orders written per psych recommendations to (decrease) Zoloft to 100 mg (milligrams) po (by mouth) dly (daily) (d/t (due to) agitation) SS (social service) observed res propelling (sic) himself to lunch today as usual and reading the Bible in his room. Res. was pleasant and cooperative during conversation today. He voiced no concerns. Res was observed with furrowed brows - his face softened during conversation while talking about his grandaughters (sic). Will continue to provide support. Documentation of agitation was lacking in the clinical record, including nurses notes, behavior monitoring sheets, and social service notes. During interview of the SSD, DON, and	F 329	termination of the responsible employee	

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F 329	Continued From page 61 Administrator on 2/25/11 at 10:00 a.m., the SSD indicated he didn't trust the quality of the information from the NP and Psych services because he has a care plan for those comments and they weren't seeing those with the nurses notes and had no behavior sheets. He also indicated he believed the NP decisions were based on her interactions with the resident. 2. On 2/23/11 at 1:24 p.m., the DNS provided a record for resident #146 titled "Consultant Pharmacist's Medication Regimen Review Pharmacist Medication Regiment Review For Recommendations Created" for the month of December 2010. "Recommendation Type: GDR...resident has been taking trazodone (a medication for insomnia) 25 mg qd (every day) since 9/10 (September 2010). Please consider a gradual dose reduction at this time (GDR), while monitoring for re-emergence and/or withdrawal symptoms. If therapy is to continue at the current dose, please provide a statement of rationale or indicate one of the following reason:...rationale for recommendation...Federal nursing regulations...require that a gradual dose reduction (GDR) be attempted twice in two separate quarters the first year, and then annually, unless clinically contraindicated..." A second record for this same month indicated "recommendation type: clinical monitoring request to follow pharmacy therapy...resident takes levothyryoxine (a medication to treat thyroid disorders) 150 mcg (micrograms) per day ...also takes simvastatin (a medication to treat high cholesterol) 40 mg (milligrams) every day...does not appear to have a TSH (thyroid stimulating hormone lab test), in her chart nor a lipid profile with LFT's (liver function tests)...If these labs have not been done recently, could it be done with her next blood work and then regularly thereafter?..."	F 329		

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F 329	Continued From page 62 The MAR's (medication administration records) for resident #146 for the month of 2/1 to 2/24/2011 indicated the resident continued to receive the trazodone, thyroxine, and simvastatin as per physician order. A review of the physician orders and physician progress notes for January and February 2011 did not indicate to make any changes in these medications. During an interview with the DNS on 2/25/11 at 9 a.m., she indicated she had checked into what happened with the pharmacy recommendations and could not locate any reason or documentation from the physician on why the GDR was not acknowledged and acted upon for trazodone, or physician documentation from MD (medical doctor) on why TSH (thyroid stimulating hormone) and LFT's (liver function tests) had not been ordered. She was also unable to locate TSH or LFT's in the laboratory clinical records as recommended by the pharmacist report and indicated "must have fallen through the cracks."	F 329		
F 334 SS=E	3.1-48(a)(2) 3.1-48(a)(3) 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 334	**F334 Influenza and Pneumococcal Immunizations** It is the practice of this provider to ensure that all alleged violations involving influenza and pneumococcal immunizations are in accordance with State and Federal law.	3/27/11

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F 334	Continued From page 63 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of	F 334	**What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Education of influenza and pneumococcal immunizations will be provided to families/residents with future vaccinations. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Resident's and resident families will receive education on influenza and pneumococcal immunizations upon admission. Resident/Family will be required to sign verification of receipt of the information and reason for declining immunizations.	

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F 334	Continued From page 64 pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure residents and/or the residents' responsible party received educational information regarding the influenza and pneumococcal vaccines, failed to ensure documentation was in the clinical record of reasons why the vaccines were not administered, and failed to ensure the Immunization Logs were complete for 5 of 5 residents reviewed for immunization in a sample of 43. [Residents # 105, 212, 66, 148, and 134] The findings include: 1. The clinical record of Resident #105 was reviewed on 2/24/11 at 9:47 A.M., and indicated the influenza vaccine was given 11/19/10. The immunization form failed to include the vaccine lot number. There was no documentation regarding the information/education provided the resident or responsible party regarding the risks/benefits of	F 334	SDC or designee will educate facility staff on documentation and administration of influenza and pneumococcal immunizations. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Infection control CQI's will be completed on a weekly basis x 4, biweekly x 2, and quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The CQI committee will review infection control CQI's in the monthly CQI meeting. Deficiency in this practice will result in disciplinary action up to and including	

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F 334	Continued From page 65 immunization. 2. The clinical record of Resident #212 was reviewed on 2/24/11 at 9:55 A.M., and did not indicate if the immunization had been given, or not. Interview with RN # 1 on the unit indicated the past Medication Administration Records [MAR] would have to be obtained to determine if the vaccine had been given because the Immunization Log was blank. The MAR was provided by the DoN on 2/24/11 at 11 A.M. and indicated the flu vaccine was given on 11/19/10. There was no information regarding the vaccine lot number on the form. There was no documentation the resident/responsible party had received educational information regarding the risks/benefits of immunization. 3. The clinical record of Resident #66 was reviewed on 2/24/11 at 10:06 A.M. and indicated the resident declined the pneumococcal and influenza vaccines. There was no indication of why the vaccines were declined. There was no documentation regarding the information/education provided to the resident regarding the risks and benefits of immunization. 4. The clinical record of Resident #148 was reviewed on 2/24/11 at 10:18 A.M. and indicated there was no documentation regarding the information/education provided to the resident regarding immunization. 5. The clinical record of Resident #134 was reviewed on 2/24/11 at 10:28 A.M. and indicated the pneumococcal and influenza vaccines were declined by the responsible party. There was no documentation regarding the reason for the declination, nor was there information regarding	F 334	termination of the responsible employee	

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F 334	Continued From page 66 the education of risks and benefits concerning the immunizations. Interview with the DoN at 10:35 A.M. on 2/24/11 indicated the facility did not provide educational information regarding the influenza and pneumococcal vaccines. Review of the facility policy, "Resident Immunization: Influenza Vaccination Pneumococcal Polysaccharide Vaccine (PPV)" on 2/24/11 at 11 A.M. indicated there were no procedures for providing information/education to the residents or responsible party regarding the vaccines. There was no procedure regarding documenting the reason for declination of the vaccines. The policy did include this procedure under Administering Vaccine: "Document on Immunization Log (vaccine, lot number, dose, site(s), etc) and in nurse's note (base line vital signs, site of immunization and post immunization vital signs)."	F 334		
F 356 SS=B	3.1-18(b)(5) 483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides.	F 356	**F356 Posted Nurse Staffing Information** It is the practice of this provider to ensure that all alleged violations involving posting of nurse staffing information is in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** No list of residents who may have been allegedly affected by this deficiency was provided. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who reside in the facility have the potential to be affected by this alleged deficient practice. The posted nurse staffing wall mount has been lowered to wheelchair eye level.	3/29/11

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F 356	Continued From page 67 o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the nursing staffing information was posted in a manner to allow accessibility to residents. Findings include: During the initial tour on 2/21/11 at 9:40 a.m., the nurse staff information was posted at a height of approximately 75 inches from the floor in the hallway across from the conference room near the facility main entrance. During an interview with the charge nurse while on initial tour, (LPN # 3), she indicated this was how the nurse staffing information was posted on a regular basis. 3.1-13(i)(4)	F 356	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Staffing Coordinator or designee will check weekly that nurse staffing data is posted at wheelchair eye level and visible for residents and visitors. Staffing Coordinator or designee will complete a staff posting audit tool once weekly x 4, bi weekly x 2, and quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The staff posting audit tool will be reviewed in the monthly QA meeting by the CQI committee. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	

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F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure menus were followed. This affected 25 residents who took their meals in the main dining room. Findings include: Per observation on 2/21/11 at 12:00 noon, twenty-five residents were observed eating their meals in the main dining room. The menu for the noon meal on 2/24/11, posted in the main dining room, indicated the following: Chili Cheeseburger Ranch Fries Marinated Cucumbers or Alternate Menu Ham and Cheese Sandwich with Lettuce, Tomato, & Mayonnaise Cole Slaw Vegetable 1. During observation of the noon meal on	F 363	**F363 Menus meet Resident Needs/Prep in Advance/Followed** It is the practice of this provider to ensure that all alleged violations involving menus meet resident needs/prep in advance/followed are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Facility met with Resident #237 and offered a different dining room seat to ensure resident #237 would receive meal earlier. Resident #237 refused the offering to change seating. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who reside in the facility have the potential to be affected by this alleged deficient practice.	

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	155329	A. BUILDING _____ B. WING _____	02/25/2011

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F 363	Continued From page 69 2/24/11, nine residents were served the alternate items of a ham and cheese sandwich with lettuce and mayonnaise. None of the sandwiches were served with tomatoes. None of the nine residents who were served the alternate sandwich in the dining room were served cole slaw, but instead were served bean salad. There was no additional vegetable served to any of the nine residents. Four residents at the end of the service were served potato chips instead of the ranch fries. The cook indicated at 12:55 p.m. that they ran out of the ranch fries and served potato chips. None of the twenty-five residents served in the main dining room, either receiving the menued items or the alternate items, received the marinated cucumbers. All residents in the dining room were instead served three bean salad. During interview with the Dietary Manager and the Registered Dietician at 3:45 p.m. on 2/24/11, the Dietary Manager indicated they ran out of cole slaw "early" and the marinated cucumbers were gone quick. 2. Observation on 2/24/11 at 12:45 P.M., indicated the noon meal was late to be served. Resident #237 had been sitting at the table in the main dining room by himself for one hour. The resident stood and walked away from the dining room at 12:45 P.M.. He was asked if he was returning and he said, "I don't know." He walked toward his room, but returned to the dining room at 12:51 P.M. No tray had been served to the resident and CNA #2 was asked if the resident was going to be served. She stated since he was gone, we told them no tray, now we have told them he is back. The resident got up and left again at 12:55 P.M. He was upset and said he	F 363	Executive Director, Dietician, or designee will provide education to Dietary Service Manager on appropriate food ordering and supply. Dietary Services Manager or designee will educate dietary staff on meal preparation, meal times, and timeliness. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Meal Service CQI's will be completed on a once weekly basis x 4, biweekly basis x 2, and then quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The CQI committee will review the meal services CQIs in the monthly QA meeting.	

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F 363	Continued From page 70 was always the last to get his food. The Executive Director was in the dining room and tried to get him to stay, but the resident would not and walked toward his room. Interview with the Executive Director on 2/25/11 indicated the facility tried to give the resident a tray three different times. The resident ended up eating in his room. Clinical record review for the resident on 2/25/11 at 1:15 P.M. indicated on 2/24/11, "Resident was upset due to lunch being late and ended up being served a tray in his room and consumed 75%." 3.1-20(i)4 3.1-21(a)(4)	F 363	Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	
F 366 SS=E	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure residents residing on the Memory Care Unit were offered substitutes of menued items promptly. This had the potential to affect 20 of 20 residents residing on the unit. Findings include: On 2/21/11 at 10:55 a.m., the noon meal was delivered to the high functioning unit of the Memory Care Unit. The dietary staff delivered the meal to the unit in large steam pans so it could be	F 366	**F366 Substitutes of Similar Nutritive Value** It is the practice of this provider to ensure that all alleged violations involving substitutes of similar nutritive value are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** A list of residents affected by the alleged deficient practice was not provided. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	3/27/11

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F 366	Continued From page 71 served family-style. There was a large pan of spaghetti with meat sauce, green beans, and breadsticks. When the nursing staff started serving the meal, one resident at the first table of four residents, indicated she wanted a hot dog or something. Staff told the resident they had spaghetti and the resident indicated she didn't want spaghetti. Staff indicated they would call down to the kitchen and see what the alternate was. There were no other alternate choices of food provided on the cart delivered by dietary at 10:55 a.m. This resident was given a dessert at 11:06 a.m. She was not offered a breadstick or green beans. Staff continued to serve the other residents in the dining room. Her tablemates ate their meal, while this resident took an occasional bite of her dessert. One of the tablemates asked why she wasn't eating and she replied, "they haven't brought it up yet." Another resident at the last table served didn't want the spaghetti and requested cereal. The staff member got a bowl of cereal and milk for the resident from the pantry area in the dining room. At 11:11 a.m., the resident decided to "try" the spaghetti. No other alternate had been delivered to the unit at that time. On 2/24/11 at 4:15 p.m., the Registered Dietician (RD) was informed that no substitutes were available during the noon meal on 2/21/11. The RD indicated they should have put 2-3 servings of the subs on the bottom of the cart for those residents who didn't want the menued item(s). 3.1-21(a)(4)	F 366	**corrective action will be taken?** All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Dietary Service Manager or designee will educate dietary staff on providing appropriate amount of alternate on the tray cart to be delivered to the memory care unit during all meals. SDC or designee will educate facility nursing staff on meal serving and offering substitutes. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Meal Service CQI's will be completed on a once weekly basis x 4, biweekly basis x 2, and then quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality**	

assurance program will be put into place?

The CQI committee will review meal services CQI in the monthly QA meeting.

Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was served, stored, and prepared in sanitary conditions. This had the potential to affect 141 residents who received their meals from the dietary department of 157 residents residing in the facility. This was noted during 2 of 2 dietary observations. The facility also failed to ensure food was served and stored under sanitary conditions in 2 of 3 pantries in the facility and 2 of 2 refrigerators in the activity/dining areas of the Memory Care Units. (February 21 and February 24) Findings include: 1. On 2/21/11 at 9:42 a.m., an initial tour of the dietary department was conducted. There were two trays of dessert for the noon meal, stored in the walk-in refrigerator. The desserts were uncovered during storage. One pitcher of juice, stored in the walk-in refrigerator was uncovered. 2. The Director of Nurses provided the Resident Census and Condition form on 2/21/11. The form	F 371	**F371 Food Procure, Store/Prepare/Serve - Sanitary** It is the practice of this provider to ensure that all alleged violations involving food procure, store/prepare/serve – sanitary conditions are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** A list of residents affected by the alleged deficient practice was not provided. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Dietary Services Manager or designee will educate dietary staff on proper food storage, handling, and sanitation.	3/27/11

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F 371	Continued From page 73 indicated there were 16 residents who did not receive meal trays. One hundred and forty-one residents residing in the facility received their meals from the dietary department. 3. On 2/24/11 at 9:20 a.m., the following was observed in the dietary department: A. The ice machine at the entry to the kitchen was soiled on the top with dirt/debris and when the lid was lifted, there was soil on the edge of the ice machine tub, including spill of a yellow substance. B. Three muffin tins were observed with a heavy build-up of soil on the exterior. C. The drawers in the preparation area, containing utensils, were soiled with dirt and debris and did not close easily. D. The bottom of the cabinet, containing plastic tubs of lids for the steam tables, was rusted, and the doors wouldn't slide easily. E. The lids to the spice jars on the shelf were soiled and greasy to the touch. F. The condiment racks of salt, pepper, and sugar were soiled with spills and debris. G. Fourteen sheet pans, stored as clean, were soiled with a heavy build-up of soil on the outside. H. A Teflon-type skillet on the cart with steam table pans, stored as clean, had a worn finish on the interior and was soiled on the outside. I. An open bag of powdered sugar in the dry	F 371	SDC or designee will educate facility staff on cleaning and food storage in pantry refrigerators. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Dietician or designee will complete a sanitation review weekly x 4, biweekly x2, then monthly thereafter Unit Manager's or designee will complete an environmental-safety CQI weekly x 4, biweekly x 2, and quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The CQI committee will review sanitation review audit tool and the environmental safety CQI's in the monthly QA meeting.	

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F 371	Continued From page 74 storage room was stored in a plastic bag which was soiled with an orange substance which was sticky to the touch. J. The exit door had a gap in the molding around it, allowing light/air to enter. K. The large open cart that held trays, plate holders, and plate covers was heavily soiled with a rusty appearance on the sides and bases and had cobwebs hanging down from the back of the cart and/or dust build-up noted. L. A dietary staff member was observed to cover the pudding dessert cups for the noon meal. In covering the trays of pudding, she reached over the trays, with her soiled apron touching the pudding dishes, with pudding noted on the apron. On 2/24/11 at 8 a.m. the Memory Care I unit refrigerator and freezer were found to contain unlabeled/undated food items. There were 2 unlabeled/undated peanut butter sandwiches wrapped in plastic, and an unlabeled/undated piece of cake covered with plastic wrap. During an interview at that time with RN#2, she indicated these were food items for the resident use and were delivered each day from dietary. She indicated it was the CNA's responsibility to discard them each morning. RN#2 immediately threw them in the trash can next to the refrigerator. There were 10 frozen dinners unlabeled/undated in the same unit freezer. RN #2 indicated these were for the families of the residents. 5. The Dietary Manager and Registered Dietician were interviewed on 2/24/11 at 4:00 p.m. No additional information was provided prior to the	F 371	Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	

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F 371	Continued From page 75 exit conference on 2/25/11 at 2:15 p.m.	F 371	**F412 Routine/Emergency Dental Services in NFS** It is the practice of this provider to ensure that all alleged violations involving routine/emergency dental services in NFS are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** A new assessment was completed on resident #237 indicating resident does have dentures present. Resident #237 has been evaluated by the dentist in reference to denture pain. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice.	
F 412 SS=D	3.1-21(i)(1) 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure 1 of 5 residents reviewed who met the criteria for oral health status in a sample of 40 residents received evaluation regarding broken dentures. [Resident #237] The findings include: 1. The clinical record of Resident #237 was reviewed on 2/24/11 at 11:30 A.M. and indicated a nursing assessment dated 1/10/11 related to dental status. The assessment indicated the resident had no upper or lower dentures. The admission Minimum Data Set [MDS] dated 1/16/11 indicated, "None of above" regarding	F 412	The SDC or designee will educate nurses on thorough	3/27/11

nursing assessments including dental assessments.

Social Services Director or designee will educate social service department on dental services.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

Assessment CQI's will be completed once weekly x 4, bi weekly x 2, and quarterly thereafter.

Dental Services CQI's will be completed monthly x 3 and then quarterly thereafter.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?

The assessment CQI's and dental services CQIs will be reviewed by the CQI Committee in the monthly QA meeting.

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F 412	Continued From page 76 broken or loose fitting full or partial dentures. Interview with the resident on 2/22/11 at 9:47 A.M. indicated the lower dentures hurt his mouth and caused his gums to hurt. He ate with them, but removed them due to sore gums. Observation during the interview indicated the resident had a tooth missing in the upper dentures. Interview with the DoN on 2/24/11 at 3 P.M. indicated she was unaware of dental problems with the resident. Interview with DoN on 2/25/11 at 9 A.M. indicated that they had gotten an evaluation planned for his dental status on 2/25/11. Record review on 2/25/11 at 1:15 P.M. indicated a dental evaluation, dated 2/25/11, that included the visit was to reline and adjust lower dentures and pre-treat for new upper and lower dentures. Interview with the resident on 2/25/11 at 2 P.M. indicated he had seen the dentist that morning and had they had taken impressions for new dentures. He stated the current dentures were worn down and "as old as he was."	F 412	Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	
F 428 SS=D	3.1-24(a)(3) 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428	**F428 Drug Regimen Review, Report Irregular, Act On** It is the practice of this provider to ensure that all alleged violations involving drug regimen review, report irregular, are in accordance with State and Federal law.	3/27/11

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F 428	Continued From page 77 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the residents' medical regimen remained free of potential adverse consequences by not acting upon pharmacist recommendations in 2 of 4 residents reviewed for unnecessary medications. This affected 2 of 10 residents sampled for unnecessary medication review. (resident #88, #146). Findings include: The record of resident #88 was reviewed on 2/23/11 at 1:24 p.m. There were two records provided from the DNS both titled "Consultant Pharmacist's Medication Regimen Review Pharmacist Medication Regiment Review For Recommendations. One of the two records related to the pharmacist recommendation for November 2010, and the second one had pharmacist recommendations for December 2010. The recommendations indicated "Recommendation Type: Drug-drug interaction", ...resident is taking her calcium and iron together at 9 a.m. and 5 p.m. To be effective--i.e. well absorbed-administer these med's (medications) at least 2 hours apart. Can these times be separated? If not , maybe dc (discontinue) one or both?" A review of the MAR's for resident #88 (medication administration record) for the months	F 428	**What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident #88's medication administration record was updated to change the administration times of the resident's calcium to differ from the administration times of the residents iron. Pharmacy recommendations for Resident #146 have been reviewed with the physician and necessary orders were obtained. Resident #146 TSH level was drawn on 01/23/2011. Resident #146 has had liver panel with LFT's done. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who reside in the facility have the potential to be affected by this alleged deficient practice.	

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F 428	Continued From page 78 of November and December 2010, January 2011, and February through the 24th, 2011 indicated the resident continued to receive the iron and calcium at the same time. An MD (medical doctor) progress note dated 11/9/10 indicated "change time of calcium per pharmacy recommendation." An MD telephone order dated 11/4/10 indicated "DC (discontinue) FESO4 (iron sulfate)". An MD telephone order dated 11/9/10 indicated "change time of calcium /vitamin d administration to 12 p.m. and 9 p.m. During an interview with the charge nurse LPN #3 on 2/24/2011 at 3 p.m. she indicated she did not know why the resident continued to receive these medications at the same time and she would write a clarification MD order. During an interview with the DNS on 2/25/11 at 9 a.m., she indicated after checking into this further, she could not find a reason for why the resident continued to receive the medications at the same time, and she was not sure why the pharmacy recommendation and MD orders were not followed through indicating "must have fallen through the cracks." 2. On 2/23/11 at 1:24 p.m., the DNS provided a record for resident #146 titled "Consultant Pharmacist's Medication Regimen Review Pharmacist Medication Regiment Review For Recommendations Created" for the month of December 2010. "Recommendation Type: GDR...resident has been taking trazodone (a medication for insomnia) 25 mg qd (every day) since 9/10 (September 2010). Please consider a gradual dose reduction at this time (GDR), while monitoring for re-emergence and/or withdrawal	F 428	DNS receives pharmacy consultant recommendations once monthly. These recommendations will be reviewed in IDT meeting. MD/NP will be notified of recommendations. Facility will continue to review recommendations in afternoon CQI meeting, Monday thru Friday until all recommendations have been addressed. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Unnecessary medication CQI's will be completed once weekly x 4, bi weekly x 2, and quarterly thereafter. The pharmacy services CQI will be completed biweekly x 2, monthly x 2, the quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 79 symptoms. If therapy is to continue at the current dose, please provide a statement of rationale or indicate one of the following reason:...rationale for recommendation...Federal nursing regulations...require that a gradual dose reduction (GDR) be attempted twice in two separate quarters the first year, and then annually, unless clinically contraindicated..." A second record for this same month indicated "recommendation type: clinical monitoring request to follow pharmacy therapy...resident takes levothyroxine (a medication to treat thyroid disorders) 150 mcg (micrograms) per day ...also takes simvastatin (a medication to treat high cholesterol) 40 mg (milligrams) every day...does not appear to have a TSH (thyroid stimulating hormone lab test), in her chart nor a lipid profile with LFT's (liver function tests)..If these labs have not been done recently, could it be done with her next blood work and then regularly thereafter?..." The MAR's (medication administration records) for resident #146 for the month of 2/1 to 2/24/2011 indicated the resident continued to receive the trazodone, thyroxine, and simvastatin as per physician order. A review of the physician orders and physician progress notes for January and February 2011 did not indicate to make any changes in these medications. During an interview with the DNS on 2/25/11 at 9 a.m., she indicated she had checked into what happened with the pharmacy recommendations and could not locate any reason or documentation from the physician on why the GDR was not acknowledged and acted upon for trazodone, or physician documentation from MD	F 428	The CQI committee will review unnecessary medication CQI's and pharmacy services CQIs in the monthly QA meeting. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	

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F 428	Continued From page 80 (medical doctor) on why TSH (thyroid stimulating hormone) and LFT's (liver function tests) had not been ordered. She was also unable to locate TSH or LFT's in the laboratory clinical records as recommended by the pharmacist report and indicated "must have fallen through the cracks." 3.1-25(j)	F 428	**F441 Infection Control, Prevent spread, Linens** It is the practice of this provider to ensure that all alleged violations involving infection control, prevention spread, and linens are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** LPN #12, was educated on infection control techniques, hand washing, and proper glove use. LPN #8 and LPN#9 were provided education on proper glucometer cleaning technique. The SDC or designee will educate the nursing staff on infection control monitoring process and documentation Rash to Resident #279 is now healed no further treatment needed.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		3/27/11

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F 441	Continued From page 81 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure infection control practices were followed for 2 of 2 observations of glucometer use in a sample of 51 diabetic residents [Residents # 283 & 172], handwashing during 2 of 8 direct care observations, [LPN # 12, 8, 9; Residents # 212 & 279] and failed to ensure the infection control nurse was informed of a resident being treated for an infectious skin rash. [Resident # 105] The facility failed to ensure staff were monitored in routine direct care practices for infection control technique. The findings include: 1. Interview with LPN #16, who was identified as the Infection Control Nurse, on 2/23/11 at 3:32 P.M. indicated she had been the infection control nurse in the facility since 2007. She described the facility's system for reporting infections as: An infection control Individual Report is filled out by the nurse and provided to LPN #16, and then she logs it into the surveillance log including: signs and symptoms, whether it was an invasive device culture date antibiotic use	F 441	The sink in the main dining room was repaired and now has hot water. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** SDC or designee will educate facility staff on proper infection control techniques, including hand washing, glucometer cleaning, glove use, and infection control monitoring process and documentation. SDC or designee will educate facility staff on infection control reporting procedures. DNS or designee educate SDC on accurate infection control monitoring. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**	

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F 441	Continued From page 82 precautions infection type. From there, she looked to see if it was a new infection, tracked it with room number, and put the resident with the infection on the layout of facility to identify trends. She filled out nosocomial infection report for month using this information. She reported she had not been aware of a physician's order, Elimite (topical treatment for Scabies) for Resident #105 in January 2011. She reported she had not received the Individual Report for this resident. The facility had treated two other residents in January 2011 for scabies. Record Review for Resident #105 on 2/24/11 at 4:16 P.M. indicated nurses notes, dated 1/23/11, "Diffuse red raised bumps noted to res [resident's] [upper] back. 0 s/s, [no signs/symptoms] itching." Notified physician. There were no further assessments of the skin, and the next nurses notes dated 1/26/11, did not mention skin. A weekly skin assessment dated 1/25/11 indicated, "old marks to body, rash on back." LPN #16 was informed of infection control technique concerns regarding glucometer use. She reported she had educated staff on a new policy for cleaning the glucometer last fall. She reported there was no formal method of monitoring staff to ensure the policy was followed. On 2/24/11 at 1:07 p.m., the DON (Director of Nurses) provided the current procedure for cleaning the glucose meter. The policy was dated 1/2010, and indicated the machines were to be cleaned using an approved germicidal pre-moistened disposable wipe. During interview	F 441	Infection Control CQI's will be completed weekly x 4, biweekly x2, and then quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The CQI committee will review infection control CQI's in the monthly QA meeting. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	

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F 441	Continued From page 83 of the DON on 2/24/11 at 3:30 p.m., she indicated the glucometers were to be sanitized using the Gluco-Chlor wipes between residents. 2. Resident # 212 was observed on 2/21/11 at 3:30 p.m. LPN # 12 was observed while changing the resident's brief. She changed the resident's incontinent of urine brief while wearing gloves. Then, without removing the gloves or washing her hands, she repositioned the resident using a stand-up lift, moved the resident into the chair, moved the lift into the hall, attached the footrests and armrest to the chair and handed the resident her water bottle for a drink. When the nurse was asked if she would have done anything differently at the time of the care, she responded, "Would probably have done things differently if had been trained as CNA and not nurse." 3. On 2/24/11 at 6:15 a.m., LPN # 8 was observed completing an accu-check (blood sugar test) for Resident #283. After completing the test, she placed the glucometer (used for blood sugar testing), in the box with the lancets (devices used to prick the finger for blood sample) and alcohol wipes. Before entering another resident room, to do another blood sugar, the LPN # 8 did remove the glucometer and sanitize with Gluco-Chlor wipes, after retrieving them from the medication room. After doing the blood sugar test, she returned the glucometer to the box of lancets and alcohol wipes, without sanitizing. Once the LPN returned to the medication cart, she removed the glucometer from the box and sanitized it. On 2/24/11 at 6:52 a.m., LPN #9 was observed to complete an accu-check for Resident #172. The LPN indicated she cleaned the glucometer prior	F 441		

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F 441	Continued From page 84 to testing, using an alcohol wipe. She completed the test for Resident #172, then proceeded to clean the glucometer again, using an alcohol wipe. She indicates she takes the alcohol wipe into the room with her so that she doesn't forget to clean the machine before returning it to the medication cart. 4. The clinical record of Resident #279 was reviewed on 2/23/11 at 1:15 p.m. The resident was admitted to the facility on 2/4/11. The Nursing Admission Assessment, dated 2/4/11 at 2:00 p.m. indicated the resident had blisters on her left hip and midback. The admission nursing note, dated 2/4/11 at 2:00 p.m., indicated the resident was admitted and had "blisters noted to (L) (left) post (posterior) hip/mid back." Nurses notes, dated 2/6/11 at 9:00 p.m., indicated, "CNA notified this writer of red rash to res (resident) (L) buttock wrapping around coxal (sic) bone to (R) (right) groin. Linear, pus filled colony of blisters noted. C/O (complains of) burning et (and) itching sensation. Supervisor et MD (Medical Doctor) notified. N.O. (new order) Famvir (anti-infective medication used to treat shingles) 500 mg (milligrams) BID (twice daily) x (for) 7 days. Placed res in contact isolation, moved roommate to different room. Appropriate infx (infection) control measures in place. WCTM (will continue to monitor)." On 2/9/11 at 2:45 p.m., nurses notes indicated Resident #279 was transferred to Memory Care Unit I and was "on contact isolation." The note indicated the resident was oriented to the unit, her room, and her roommate.	F 441		

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F 441	Continued From page 85 Nurses notes indicated the following: 2/21/11 3:40 a.m. ". . .Shingles drying." 2/21/11 12 noon ". . .no skin break noted do have scab areas on back et buttock (sic). . ." Resident #279 was interviewed on 2/22/11 at 9:25 a.m. During the interview, an isolation cart was observed in the resident's room and a sign on the door indicated visitors were to report to the nurse prior to entering the room. The DON (Director of Nurses) was interviewed on 2/23/11 at 3:30 p.m. regarding the placement of isolation (contact precautions) on 2/6/11 and the moving of the resident's roommate from the room and later moving the resident to another unit with a roommate. The DON indicated she would research the matter. On 2/25/11 at 8:30 a.m., the DON provided information which indicated the resident was placed on contact precautions related to the diagnosis of shingles. She indicated the facility had no policy for isolation for shingles but the facility only requires standard precautions for shingles since shingles is only contagious to those who have not had chicken pox. The policy for "Implementing Standard Precautions," dated July 08, was provided for review by the DON on 2/25/11 at 9:15 a.m. The policy indicated: ". . .3. When a resident has a rash or skin lesion. a. A rash or skin lesion on a resident's body can be due to any number of causes. b. A critical index of suspicion is essential to determine if the rash is due to:	F 441		

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F 441	Continued From page 86 Varicella (chicken pox or shingles) Scabies Impetigo Herpes Simplex Syphilis A drug reaction Other causes c. The most important intervention for rashes or skin lesions is to inform the physician and determine its cause promptly. d. Many times prompt recognition of the rash, identification of the cause, and prompt appropriate intervention can prevent transmission to the HCW (health care worker) and other residents. e. Wear gloves when care involves contact with the rash. A gown may be necessary. . ." On 2/23/11, a physician's telephone order indicated the resident was removed from isolation precautions secondary to the areas being healed. 5. On 2/24/11 at 9:20 a.m., the sink in the main dining room, beside the ice machine had no hot water service. All employees serving trays for the noon meal in the dining room on 2/24/11, (6-8 employees throughout the meal) were observed to use this sink for handwashing prior to serving the meal. Staff members commented that the temperature of the water couldn't not be adjusted and the water was cold. On 2/24/11 at 3:45 p.m., a corporate staff member was notified the hot water did not function at the handwashing sink, and he indicated he would have maintenance repair that as soon as possible. The policy for Handwashing, dated July 08, was	F 441		

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F 441	Continued From page 87 provided by the Director of Nurses on 2/24/11 at 4:24 p.m. The policy indicated the water was to be turned on to a "comfortable temperature" and indicated, "Luke warm (sic) water seems to be less drying to skin." 3.1-18(b)(1)	F 441	**F464 Requirements for Dining and Activity Rooms** It is the practice of this provider to ensure that all alleged violations involving requirements for dining and activity rooms are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** A list of residents affected by the alleged deficient practice was not provided. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. The location of the dining room was moved to a more spacious area with new table arrangements.	
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure dining rooms had sufficient space to accommodate residents. This was observed in 1 of 5 dining rooms and had the potential to affect 33 of 33 residents served meals in the room. (Rose Cafe) Findings include: On 2/24/11 at 8:14 a.m., the Rose Cafe was observed during the morning meal. One resident, seated at the back table, was finished and trying to leave the dining area. The resident was self-propelling her wheelchair but couldn't get through for the remainder of the wheelchairs at the next table. The resident stated, "I can't move my chair, there are too many people in here." A staff member indicated, "she's almost finished	F 464		3/20/11

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F 464	Continued From page 88 eating," referring to the resident in the chair blocking the resident - you'll have to wait a few minutes. The resident then stated again, can someone help me, to which the staff member replied, you'll have to wait a few minutes - she's almost finished eating. If this resident blocking the resident had been moved, the resident would have still been unable to get through for other residents. The resident stated, "I'm not coming in here anymore." Staff again told the resident she would need to wait until the resident finished before leaving the dining area. On 2/24/11 at 11:15 a.m., the noon meal was observed in the Rose Cafe. There were 14 tables, serving 33 residents in the room. Only 1 of the 33 residents was ambulatory. There were 8 residents in geri-chairs, with feet extended. There was no ability to maneuver between tables, without difficulty, and any resident in a wheelchair would have been unable to get out of the room, without staff assistance to move residents out of the way. On 2/24/11 at 3:30 p.m., the Administrator indicated, during interview, that they had an action plan to move the Rose Cafe residents to another area for dining that would provide additional room.	F 464	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Meal observation CQI will be completed once weekly x 4, bi weekly x 2, and quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The CQI committee will review the meal observation CQI in the monthly QA meeting. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	
F 465 SS=E	3.1-19(v) 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465	**F465** **Safe/Functional/Sanitary/ comfortable Environment** It is the practice of this provider to ensure that all	3/27/11

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F 465	Continued From page 89 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility was maintained in a sanitary condition for residents, staff, and the public. This was noted in the dietary department and common areas of the facility and had the potential to affect 157 of 157 residents residing in the facility. Findings include: 1. On 2/24/11 at 9:20 a.m., the dietary department was observed. The following was noted: A. The floor in front of the ice machine and to the left of the ice machine was heavily soiled with a build-up of a brown substance, which did scrape off with the fingernail. B. The sink at this entrance did not have functioning hot water. C. The kitchen floor was soiled with dirt and debris throughout with heavier soiling noted around the perimeter of the room and in the corners of the room. D. The tile wall next to the preparation area was soiled with spills and the white grout was discolored and soiled. E. The floor in the dry storage room was heavily soiled with spills of a white powder substance.	F 465	alleged violations safe/functional/comfortable /environment are in accordance with State and Federal law. **What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** A list of residents affected by the alleged deficient practice was not provided. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who reside in the facility have the potential to be affected by this alleged deficient practice. The floor in front of the ice machine and to the left of the ice machine was cleaned. The sink at the entrance of the kitchen was repaired and has hot water The kitchen floor was cleaned.	

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F 465	Continued From page 90 F. The walls to the left of the dishwasher were soiled with yellow spills. G. The threshold to the exit door near the dry storage room was heavily soiled. H. The covers over two of three lights over the preparation area were cracked/broken and uneven. I. The wood baseboard on entry to the kitchen was heavily soiled with dirt/dust. 2. During an observation on 2/23/11 between 2:50 p.m.-3 p.m., the bottom panels on the fire exit doors on F, G & H halls (3 total) were noted to have dry rotted/cracked wood loose from floor approximately 8 ft long and about 1 inch from the floor, with a gap between the floor and floor panel allowing air to be felt entering the building. On 2/23/11 at 3 p.m., the service hall door on the E hall was observed to have a floor door strip unsecured to the floor exposing a gap approximately 8 x 1 inches, black scuff marks, and chipped paint. The maintenance supervisor was nearby and was made aware of this finding. On 2/23/11 at 3 p.m., the service hall door on E hall was observed to have a door strip on floor unsecured to the floor exposing a gap 8 x 1 inches, black scuff marks with chipped paint. The maintenance supervisor was nearby and was made aware of findings. On 2/23/11 at 3:05 p.m., the C hall fire exit door was noted to have a crack in the floor frame and was loose from the floor.	F 465	The tile wall next to the preparation area was cleaned The floor in the dry storage area was cleaned The walls to the left of the dishwasher were cleaned The threshold to the exit door near the dry storage room was cleaned The covers over three of two lights over the preparation area were replaced. The wood base board on the entry to the kitchen was cleaned The bottom panels on the fire exit doors on F, G, and H were repaired The service hall door on E hall door strip was repaired and door was painted. The C hall fire exit door floor frame was repaired **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Department head team to do daily nursing rounds daily Monday thru Friday, excluding holidays and report findings to IDT team in afternoon CQI meeting.	

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	155329	A. BUILDING _____ B. WING _____	02/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 91 The maintenance supervisor was interviewed on 2/25/11 at 9 a.m. to discuss the multiple findings in general affecting the resident environment. He indicated he and the administrator were aware of the situation and were working to correct the situation. He indicated he has several painters and other workers currently in the building addressing these multiple environmental findings. 3.1-19(f)	F 465	Nursing Rounds CQI will be completed once weekly x 4, bi weekly x 2, then quarterly thereafter. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The CQI committee will review the nursing rounds CQI's in the monthly QA meeting. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	**F520 QAA committee-Members/Meet Quarterly Plans** It is the practice of this provider to ensure that all alleged violations involving QAA committee-Members/Meet quarterly plans are in accordance with State and Federal law.	3/27/11

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F 520	Continued From page 92 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure the quality assurance committee functioned effectively to identify and address the concerns identified by the survey conducted from 2/21/11 through 2/25/11. This potentially affected all 157 residents. Findings include: The Administrator and Director of Nursing [DoN] were interviewed on 2/24/11 at 3:20 p.m. to discuss the quality assurance program. They were questioned about the program ' s function in the facility in regards to identifying and addressing problems. The Administrator and DoN indicated the facility had a computer program which identified problems and each month the department head was given a computer print out to follow. The computer followed such things as falls, residents rights, and the environment. The problem area of resident room cleanliness and upkeep was discussed. An action plan for environmental changes and remodeling was provided by the DoN and Administrator on 2/25/11 at 10 a.m. It had no date of identification, nor was there a starting date. The quality assurance program had not addressed the problem of resident room cleanliness and upkeep. Infection Control was discussed as a concern, particularly with handwashing and glucometer use. The Administrator and DoN provided an action plan regarding handwashing on 2/25/11 at 10:00 a.m. There was no date on the plan, nor	F 520	**What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** A list of residents affected by the alleged deficient practice was not provided. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Quality Assurance meetings held monthly with the Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, Social Service Director, Rehab Manager, Dietician, Maintenance, Housekeeping, Activities, Dietary Manager, and other Department Heads. **What measures will be put into place or what systemic changes will you make to ensure that the**	

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F 520	Continued From page 93 was there indication of resolution of the problem. There was no action plan to ensure infection control practices were followed with the glucometer. The problem of falls was discussed as a concern. The Administrator and DoN provided an action plan for falls on 2/25/11 at 10:00 a.m., which had no date, nor indication the problem had been resolved or the plan revised. Dietary sanitation was discussed. There was no action plan provided to ensure the provision of food that had been stored and served under sanitary conditions. The administrator was given the opportunity to present any other information about the quality assurance program and its effectiveness prior to the exit at 2:00 p.m. on 2/25/11. No other information was presented. 3.1-52(b)(2)	F 520	**deficient practice does not recur?** CQI tools will be assigned monthly per CQI manual schedule. Assigned CQI tools will be reviewed in the monthly QA meeting, notes will be taken, and any CQIs that do not meet facility thresholds will have actions plans created and be reviewed in the following months QA meeting. The ED will complete the Administration-General CQI and then quarterly thereafter **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The CQI committee will review the Administration General CQI in the monthly QA meeting. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	